



Life and Health Insurance

Pennsylvania

State Law Supplement

**Financial
Education**



**KAPLAN
UNIVERSITY**

SCHOOL OF PROFESSIONAL
AND CONTINUING EDUCATION

Life and Health Insurance

Pennsylvania

Effective July 1, 2015

State Law Supplement

Important: Check for Updates

States sometimes revise their exam content outlines unexpectedly or on short notice. To see whether there is an update for this product because of an exam change, go to **www.kaplanfinancial.com** and check the Insurance Licensing Blog. If there is an update, it will be clearly noted in the blog entries for this state.

Financial
Education



KAPLAN
UNIVERSITY

SCHOOL OF PROFESSIONAL
AND CONTINUING EDUCATION

At press time, this edition contains the most complete and accurate information currently available. Owing to the nature of license examinations, however, information may have been added recently to the actual test that does not appear in this edition. Please contact the publisher to verify that you have the most current edition.

This publication is designed to provide accurate and authoritative information in regard to the subject matter covered. It is sold with the understanding that the publisher is not engaged in rendering legal, accounting, or other professional services. If legal advice or other expert assistance is required, the services of a competent professional should be sought.

PENNSYLVANIA LIFE AND HEALTH INSURANCE LAW
SUPPLEMENT, EFFECTIVE JULY 1, 2015
©2015 Kaplan, Inc.

The text of this publication, or any part thereof, may not be reproduced in any manner whatsoever without written permission from the publisher.

If you find imperfections or incorrect information in this product, please visit www.kaplanfinancial.com and submit an errata report.

Published in August 2015 by Kaplan Financial Education.

Printed in the United States of America.

ISBN: 978-1-4754-3304-3

PPN: 3200-6467

Contents

Introduction v

S E C T I O N 1 Cram Sheets 1

S E C T I O N 2 Class Notes 5

S E C T I O N 3 Detailed Text 63

S E C T I O N 4 Practice Exam 141

Introduction

What is a State Law Supplement?

This book focuses on the state-specific statutes and regulations on the state exam content outline. In order to be fully prepared for the exam, you must understand completely both the national License Exam Manual and this supplement.

How is the supplement organized?

In order to make this book flexible and easy to use, we've divided it into four sections, and are each broken into topic areas as seen below.

Section	Topic Areas
Cram Sheets Cram sheets focus on very specific details for your state. The information is presented in an easy to understand table format primarily highlighting days, dates, and dollars.	■ General Insurance Law ■ Life Insurance Law ■ Health Insurance Law
Class Notes The class notes are meant to be a summary of the key topics in the law supplement, and are available to all students—classroom and self-study.	■ General Insurance Law ■ Life Insurance Law ■ Health Insurance Law
Detailed Text The text section is the most detailed section of the law supplement. All topics in your state's exam content outline law and regulations section are covered.	■ General Insurance Law ■ Life Insurance Law ■ Health Insurance Law
Practice Exams The practice exams test your retention of the law supplement material.	■ General Insurance Law ■ Life Insurance Law ■ Health Insurance Law

Do I have to learn everything in this book?

Not necessarily! The table below shows the sections you should study depending on the exam you are preparing for.

State Exam	Sections to Study
Life and Health Insurance	General (All Lines), Life, and Health Insurance
Life Insurance Only	General (All Lines), and Life Insurance only
Health Insurance Only	General (All Lines), and Health Insurance only

How should I study this information?

Below is a best study practice for the law and regulations section of your exam.

1. **Law Supplement Cram Sheet:** Your exam will probably ask about specific fine amounts or days' notice requirements (e.g., changing your address).
2. **Law Supplement Class Notes:** Reading the class notes exposes students to the majority of topics covered in the law supplement.
3. **Law Supplement Detailed Text:** Read this text for more in-depth descriptions of the state's insurance laws and regulations.
4. **Law Supplement Practice Exams:** There are two law supplement practice exams. One is in the back of the law supplement. State specific law questions can also be found in the InsurancePro™ QBank at www.kaplanfinancial.com.
5. In your final preparation for the exam take the time to again review the **cram sheet** and **class notes**. Use them as a last-minute refresher of the most important law and regulation testable topics.



1

Cram Sheets

HOW TO USE: In your final preparations for your insurance exam use this cram sheet to memorize key days, dates, and dollars. A suggested technique is to cover the left hand column; read the right hand column; then uncover the left hand column to reveal the correct answer.

PENNSYLVANIA LAWS AND REGULATIONS APPLICABLE TO ALL LINES

Licensing

24 hours	Prelicensing education requirement
Age 18	Minimum age to obtain producer's license
180 days	Length of temporary insurance producer license, without requiring an examination if a licensed producer dies, becomes disabled, or enters active military service

License Maintenance and Duration

2 years	Producer licenses are issued for a term of ____
1 year	A lapsed producer's license may be reinstated within ____ year(s) of the license renewal date.
30 days	Producer's time to notify the Commissioner of change of address, administrative actions, or criminal charges
24 hours 24 hours	Continuing Education Requirement for each two-year CE term Number of hours that may be carried forward to next CE term

Commissioner

10 days	The Commissioner must give ____ days' notice of a hearing
\$5,000	Maximum producer fine per violation of the insurance code
\$1,000 \$10,000 \$5,000 \$50,000	Unfair Competition, Act, or Practice civil penalties \$____ per violation for nonwillful violations \$____ aggregate penalty for nonwillful violations \$____ per violation for willful violations \$____ aggregate penalty for willful violations
5 years	The Commissioner must examine rating organizations at least once every ____ years
30 days	Rates must be filed for ____ days before use
30 days	Life, accident, or health insurance policy forms must be filed and approved by the Commissioner. Once forms have been filed, they are considered approved after ____ days unless the Commissioner rejects them.
5 years	The Commissioner must conduct an examination of every licensed insurer at least once every ____ years

Insurance Fraud Regulations

\$5,000 \$10,000 \$15,000	A person found guilty of insurance fraud is subject to the following civil penalties: ____ for the first violation ____ for the second violation ____ for each subsequent violation
---------------------------------	--

Claims Practices

10 days	Insurers must acknowledge a claim and provide claim forms within ____ working days Insurers must respond to a commissioner inquiry within ____ working days
15 days 30 days 15 days	Insurer must provide an explanation to the insured if a claim investigation cannot be completed within ____ days First party claims must be settled within ____ working days

PENNSYLVANIA LAWS AND REGULATIONS APPLICABLE TO LIFE INSURANCE

3 years	The replacing insurer and the existing insurer must keep replacement transaction records for ____ years after the transaction or until the next Commissioner's examination, whichever is sooner
Policy Provisions	
8%	Maximum policy loan annual fixed interest rate
10 days 45 days 20 days	<i>Free look</i> for life insurance <i>Free look</i> for internal (same insurer) replacement of life insurance <i>Free look</i> for external (other insurer) replacement of life insurance
30 days	Grace period
25% and 100%	An accelerated death benefit must be at least ____%, but no more than ____%, of the total death benefit
Viatical Settlements	
2 ADLs	<i>Chronically ill</i> is being unable to perform at least ____ activities of daily living (ADLs) or requiring substantial supervision due to cognitive impairment
24 months 30 days 15 days	<i>Terminally ill</i> is having an illness that is expected to result in death in ____ months or less The viator has a <i>right to rescind</i> the contract for ____ days from the contract date and for at least ____ days after receiving the Viatical settlement proceeds

PENNSYLVANIA LAWS AND REGULATIONS APPLICABLE TO ACCIDENT AND HEALTH INSURANCE ONLY

Not allowed 12 months 3 years 12 months	<i>Maximum</i> Preexisting Condition Exclusion period if allowed <ul style="list-style-type: none"> ■ Individual and group policies subject to the Affordable Care Act (ACA) ■ Group policies not subject to ACA ■ Individual policies not subject to ACA (Time Limit on Certain Defenses health policy provision) ■ Individual policies issued on a nonmedical basis (simplified issue)
30 days	<i>Probationary periods</i> must not exceed ____ days
10 days 30 days	<i>Free look</i> for health insurance <i>Free look</i> for long-term care insurance and Medicare supplements
3 years	Time limit on Certain Defenses (Incontestability) health policy provision
Affordable Care Act (ACA)	
Age 26	Dependent coverage continues until the dependent's age ____
60% 70% 80% 90%	<i>Health Insurance Marketplace</i> four levels of coverage (metal tiers) <i>Bronze plans</i> cover ____% of medical expenses <i>Silver plans</i> cover ____% of medical expenses <i>Gold plans</i> cover ____% of the medical expenses <i>Platinum plans</i> cover ____% of medical expenses
Long-Term Care (LTC)	
12 months	Minimum benefit period
5%	Minimum inflation protection percentage
50% 10%	<i>Permitted compensation</i> : <ul style="list-style-type: none"> ■ First-year commissions may not be greater than ____% of the first year premium ■ Renewal commissions may not exceed ____% of the renewal premium
6 months	Maximum preexisting condition exclusion period
3 \$10,000	The penalties for violating LTC regulations are up to ____ times the amount of any commissions paid for each policy involved in the violation, or \$____, whichever is greater.

Medicare Supplements	
No more than 200% of servicing compensation	<i>Permitted compensation:</i> Maximum first year compensation
6 months	<i>Open enrollment</i> within ____ of enrolling in Medicare Part B, and being age 65 or older
63 days	<i>Guaranteed issue</i> is available those who had prior group health coverage or Medicare Advantage who apply for a Medicare supplement within ____ days after the date of termination or disenrollment of the prior coverage



2

Class Notes

HOW TO USE: The class notes are an excellent place to start when studying the state specific laws and regulations. The class notes are a summary of the key law supplement topics. For some students the class notes may be their primary section to study the law and regulation exam material.

Pennsylvania Laws and Regulations

Applicable to All Lines of Insurance

© 2015 Kaplan University School of Professional and Continuing Education 1

Licensing Process

- Pre-licensing education requirements
 - 24 credit hours
 - Three of the 24 hours must be in ethics.

© 2015 Kaplan University School of Professional and Continuing Education 2

Licensing Process

- License exam and prelicensing education exemptions
 - Business entity
 - Nonresident producers
 - Professional designations
 - CLU[®]—Life and Health license
 - CPCU[®]—Property and Casualty license
 - CIC[®]—Life, Health, Property, and Casualty licenses
 - Line of authority is only limited line credit insurance
 - Line of authority restricted to limited line
 - Line of authority restricted to fraternal insurance

© 2015 Kaplan University School of Professional and Continuing Education 3

Licensing Process

- Qualifications for a license
 - Must be at least age 18
 - Have not committed any prohibited act under insurance laws
 - Satisfied pre-licensing education requirements
 - Passed or is exempt from licensing examination
 - Paid applicable fees

Types of Licenses

- Producer
 - A person may not sell, solicit, or negotiate a contract of insurance in Pennsylvania unless licensed as an insurance producer for the line of authority under which the contract is issued.

Types of Licenses

- Nonresident
 - An individual who is currently licensed as a resident insurance producer in another state or territory may apply to the Department for a nonresident insurance producer license for the same lines of authority as in their home state.
 - Reciprocity—Department may waive requirements for nonresident license in Pennsylvania if producer's home state awards the same to Pennsylvania producers.

Types of Licenses

- Temporary license—May be issued to surviving spouse, employee, or court-appointed representative if a producer dies, becomes disabled, or enters active military service.
 - Temporary license may not exceed 180 days and is not transferable.
 - Person may not use temporary license to transact new insurance business.
 - Purpose of temporary license is to maintain, transfer, or conclude existing business.

Types of Licenses

- Managers and exclusive general agents
 - Anyone acting as a manager or exclusive general agent must be licensed.
 - Violation is considered a third degree misdemeanor.
 - Fine of up to \$1,000 per day

Types of Licenses

- The following lines of authority may require a license:
 - Property insurance
 - Casualty insurance
 - Personal lines
 - Limited line credit insurance
 - Motor vehicle rental
 - Limited lines, as determined by the Commissioner
 - Life insurance
 - Accident and health or sickness insurance
 - Variable life and annuity products

License Renewal

- Producer licenses renew every 24 months in the producer's birth month.
- Licensee must:
 - submit renewal form;
 - pay renewal fee; and
 - complete continuing education (CE) requirement.

© 2015 Kaplan University School of Professional and Continuing Education 10

Maintenance and Duration

- License reinstatement
 - Licensee may request reinstatement within one year of lapse.
 - Reinstatement is effective retroactively back to the lapse date if reinstated within 60 days after the license lapsed.
 - Reinstatement is effective on the date of reinstatement if reinstated more than 60 days after the license lapsed.
 - If a person applies for reinstatement more than one year after the lapse date, the person must reapply for a license.

© 2015 Kaplan University School of Professional and Continuing Education 11

Reporting of Actions

- **Administrative action**—A licensee must report to the Department any administrative action taken against the licensee in another jurisdiction or by another governmental agency in Pennsylvania within **30 days** after the final disposition of the matter.
- **Criminal conduct**—A licensee must report to the Department within **30 days** of being charged with criminal conduct.

© 2015 Kaplan University School of Professional and Continuing Education 12

Maintenance and Duration

- Assumed names
 - License may only be issued in name of applicant or business entity.
 - Licensee must notify Commissioner in advance if fictitious name is to be used.
- Address change
 - Licensee must notify Commissioner within 30 days of any change in address.

Continuing Education (CE)

- Must complete 24 credit hours for each two-year license period
 - Licensee may carryover up to of 24 hours to the next licensing period.
- The following licensees are exempt from CE requirement:
 - Licensees continuously licensed prior to 01/01/1971
 - Business entities
 - Limited line and limited line credit insurance licensees
 - Licensees with only fraternal line of authority
 - Nonresident licensees

Disciplinary Actions

- If the Commissioner suspects an insurance violation, the Commissioner will hold a hearing regarding the alleged violation.
 - At least 10 days notice of the hearing is required.
- After the hearing, if a violation is found, the Commissioner may:
 - deny, suspend, refuse to renew, or revoke the license;
 - assess a civil penalty up to \$5,000 for each violation; or
 - issue a cease and desist order.

Disciplinary Actions

- Maximum fines
 - Unfair competition where person knew it was a violation
 - \$5,000 for each violation
 - \$50,000 in aggregate in any six-month period
 - Unfair competition where person did not know it was a violation
 - \$1,000 for each violation
 - \$10,000 in aggregate in any six-month period
 - Violation of a Commissioner's order
 - Up to \$10,000

Commissioner

- Executes insurance laws to protect the public interest
- Issues, suspends, or revokes licenses
- Regulates insurer solvency, and approves policy forms and insurance rates
- May not be a director, officer, or producer of an insurer
- Is appointed by governor for a four-year term

Commissioner

- Issues rules and regulations to implement and administer the insurance code, *but may not change the code itself*
- Participates in the National Association of Insurance Commissioners (NAIC) centralized insurance producer license registry for submitting or obtaining information on insurance producers

Producer Appointment

- An insurance producer may not act on behalf of or as a representative of an insurer unless appointed by the insurer.
 - The insurer must file a notice of appointment of the producer with the Department.
- If representing a consumer (as opposed to insurer), the producer must execute a written agreement with the consumer regarding delineation of services.
 - There must be full and complete disclosure of fee to be paid to the producer by the consumer.

Producer Appointment

- Termination—Producers remain appointed with insurer until appointment is terminated in writing or until producer’s license is suspended, revoked, or otherwise terminated.
 - The insurer must notify the Department in writing within 30 days following effective date of termination.
 - The insurer must mail copy of notification to licensee within 15 days of notification.
 - Licensee may file written comments regarding notification within 30 days of receipt.

Regulation of Insurer Solvency

- Insurers doing business in Pennsylvania must maintain specified minimum levels of capital stock and surplus.
 - Amount depends on line of insurance and how company is organized.
- Domestic insurers must submit report of risk-based capital levels to Commissioner and the NAIC every year by March 1.

Rate Regulatory Act

- Insurance rates must not be excessive, inadequate, or unfairly discriminatory.
- Commissioner examines all rating and advisory organizations at least once every 5 years.
 - Organization pays cost for examination.

© 2015 Kaplan University School of Professional and Continuing Education 22

Approval of Policy Forms

- Life and health policy forms must be approved by commissioner prior to use.
 - Once filed, the forms are considered approved after 30 days unless rejected.
 - Commissioner must notify insurer to extend the review for another 30 days.
- Disapproval and appeals
 - If a form is disapproved, commissioner notifies insurer in writing.
 - Insurer may request a hearing within 30 days of the notice.
 - Hearing must be held within 30 days after Commissioner receives request for hearing.

© 2015 Kaplan University School of Professional and Continuing Education 23

Insurer Examinations

- Examination of books and record
 - The Department may conduct examinations of insurers whenever deemed appropriate, but at least once every 5 years.

© 2015 Kaplan University School of Professional and Continuing Education 24

Producer Regulation

- Fiduciary responsibility
 - Insurance producer will be responsible in a fiduciary capacity for all funds collected or received.
 - May not commingle funds with own funds
 - Funds of each insurer must be identifiable from producer records.

Commissions and Fees

- Insurers and producers may pay commission or other compensation to a licensee for selling, soliciting or negotiating a contract of insurance.
 - May not pay commission to unlicensed person
 - Renewal or deferred compensation may be paid if the person was licensed at time of sale but is no longer licensed.
 - May pay one-time nominal referral fee to unlicensed person for each referral that does not depend on sale

Prohibited Acts

- A licensee or applicant for an insurance producer license may not:
 - provide incorrect, misleading, incomplete, or false information to the Department in a license application;
 - violate the insurance laws or regulations;
 - obtain or attempt to obtain a license through misrepresentation or fraud;
 - improperly withhold, misappropriate, or convert money or property received in the course of doing business;
 - intentionally misrepresent the terms of an insurance contract or application for insurance;

Prohibited Acts

- A licensee or applicant for an insurance producer license may not (continued):
 - commit any unfair insurance practice or fraud;
 - have an insurance producer license denied, suspended, or revoked by a governmental entity;
 - knowingly accept insurance business from an unlicensed person;
 - use fraudulent, coercive, or dishonest practices;

Prohibited Acts

- A licensee or applicant for an insurance producer license may not (continued):
 - fail to pay child support;
 - fail to pay state income tax;
 - commit a felony or its equivalent;
 - commit fraud, forgery, dishonest acts, or an act involving a breach of fiduciary duty;
 - fail to notify the Department of a change of address within 30 days; or
 - demonstrate lack of general fitness, competence, or reliability.

Unfair Insurance Practices

- Rebating
 - Offering valuable consideration or inducement to or for insurance on a risk
- Tie-in sales prohibited
 - A financial institution may not require purchase of insurance from a specific insurer or producer as a condition of any loan or deposit transaction.
- Misrepresentation
 - Making written or oral statements misrepresenting terms of policy or contract
 - Making statements that dividends are guaranteed

Unfair Insurance Practices

- Twisting
 - Making misrepresentations or incomplete comparisons of policies to insureds in order to induce policy lapse, forfeit, or surrender of insurance to write a new policy with similar risks with another carrier
- Defamation
 - Making or issuing an oral or written statement that is false, derogatory, or maliciously critical to the financial condition of a person or insurer

Unfair Insurance Practices

- **False advertising** is the making or circulating of an advertisement containing any statement regarding the business of insurance or any person in the insurance business that is untrue, deceptive, or misleading.
- It is prohibited to make, publish, or circulate any advertisement that:
 - misrepresents benefits, conditions, terms, or dividends of a policy;
 - misrepresents the financial condition of person or insurer; or
 - uses an insurance policy name that misrepresents its true nature.

Unfair Insurance Practices

- Boycott, coercion, and intimidation
 - Engaging in action or agreement that would result in unreasonable restraint or monopoly of insurance business
- Misappropriation of funds
 - Producer who embezzles or fraudulently converts money to his own use while negotiating a contract is guilty of theft.

Unfair Insurance Practices

- **Unfair discrimination**—Underwriting standards must not be based on race, religion, nationality or ethnic group, age, sex, family size, occupation, place of residence, or marital status.
 - It is unfair discrimination to charge different premiums or extend different benefits to individuals of the same class and essentially same hazard.
- **Illegal inducement** is the offering of anything not stated in insurance contract, including a rebate of premiums, special favors, or dividends.
 - Illegal inducement is a third-degree misdemeanor.

Privacy

- A licensee may not disclose nonpublic, personal financial information about a consumer to a nonaffiliated third party unless:
 - consumer has received initial privacy notice; and
 - consumer has received an opt-out notice and has not opted out.
- Licensees must provide a privacy notice to customers at least once in any 12 consecutive months.

Financial Institution Sales

- Licensees employed by a financial institution soliciting annuities or life insurance sales (except credit life insurance) must provide applicants with a written disclosure at or prior to the time of application stating:
 - the insurance or annuity is not a deposit;
 - the insurance or annuity is not insured by the FDIC or any other federal agency;
 - the insurance or annuity is not guaranteed by the financial institution; and
 - the insurance or annuity is subject to investment risk, including potential loss of principal.

Financial Institution Sales

- Financial institutions must have a separate area for sales of annuities or insurance distinct from the area where deposits and loan applications are discussed and accepted.
 - Signs must be used to distinguish insurance and annuity sales area from lending and deposit area.
 - Commissioner must exempt financial institution if number of staff or size of the facility prevents compliance.

Insurance Fraud

- A person commits an offense if, knowingly and with the intent to defraud, that person:
 - presents false, incomplete or misleading claim information;
 - conspires with another person by submitting false claim information;
 - intentionally engages with an unlicensed producer or unauthorized insurer;
 - knowingly benefits directly or indirectly from a violation;
 - is an owner, administrator, or employee of any health care facility which allows another person to use the facility to further a scheme or conspiracy; or
 - uses another person's insurance identification card to present a fraudulent claim.

Insurance Fraud

- Civil penalties per violation
 - First violation—\$5,000
 - Second violation—\$10,000
 - Each subsequent violation—\$15,000
- Insurance Fraud Prevention Act
 - Purpose
 - To coordinate and fund fraud prevention activities
 - Support enforcement of insurance fraud laws
 - Administered by Insurance Fraud Prevention Authority

Unfair Claim Settlement Practices

- Unfair claim practices include:
 - misrepresenting policy provisions;
 - failing to acknowledge and respond to claim communications;
 - failing to implement reasonable standards for the prompt investigation of claims;
 - failing to settle promptly when liability is reasonably clear to influence settlements under other parts of the policy;
 - compelling insureds to institute litigation to recover amounts due under policies by offering substantially less than the amounts ultimately recovered in actions brought by the insureds;

Unfair Claim Settlement Practices

- Unfair claim practices include (continued):
 - making known to claimants a policy of appealing arbitration awards to compel claimants to accept a compromise less than the amount awarded in arbitration;
 - attempting to settle a claim based on an altered application;
 - failing to state the coverage for which payment is made;

Unfair Claim Settlement Practices

- Unfair claim practices include (continued):
 - delaying an investigation or payment of a claim by requiring an insured's physician to submit a preliminary claim report and subsequently to submit formal proof of loss forms that contain substantially the same information; and
 - failing to affirm or deny coverage of claims within a reasonable time.

Claims Practices

- Department inquiries must be responded to within 15 working days.
- If a claim investigation cannot be completed within 30 days, the insurer must provide the claimant with a written explanation for the delay and state when a decision may be expected.
- Within 15 working days after the insurer receives the proof of loss, the first-party claimant must be advised of the acceptance or denial of the claim.

NAIC

- National Association of Insurance Commissioners (NAIC)
 - Organization formed to promote uniformity in state insurance laws
 - Prepares model laws that commissioners may represent to their respective legislators

Advertising Requirements

- Definition of advertisement
 - Printed, audio, and visual literature used in direct mail, newspapers, magazines, radio/TV, sales talks, presentations, and materials used by agents, brokers, or solicitors
- Advertisements must be:
 - complete and clear to avoid deception; and
 - truthful and not misleading in fact or implication.
- Advertising file
 - Company must maintain file of all advertisements.
 - File must be kept for four years.

Advertising Requirements

- Testimonials and endorsements
 - Must be genuine, current, and accurate
 - Must state if the person is being paid
- Prohibited advertising of guaranty fund
 - It is unlawful to use the existence of a guaranty fund as an inducement to purchase any kind of insurance protected by the fund.

© 2015 Kaplan University School of Professional and Continuing Education 46

Fraud and False Statements

- If found guilty, certain types of false or fraudulent statements have been specifically outlined in federal law as punishable by the following penalties:
 - A fine
 - Imprisonment for up to 10 years
 - Both of the above
- Imprisonment can be ordered for up to 15 years if the false statements jeopardized the safety and soundness of an insurer and were a significant cause of the insurer being placed in conservation, rehabilitation, or liquidation by the courts.

© 2015 Kaplan University School of Professional and Continuing Education 47

Fraud and False Statements

- Fraudulent actions, statements, or reports include the following:
 - Overvaluing of any land, property, or security
 - False financial condition or solvency of a business in insurance
 - Willfully embezzling, abstracting, purloining, or misappropriating any moneys, funds, premiums, etc.
 - Corruptly influencing, obstructing, or impeding the due and proper administration of the law under which any proceeding is pending

© 2015 Kaplan University School of Professional and Continuing Education 48

Fair Credit Reporting Act

- All insurers and their producers must comply with this act regarding information obtained from a third party concerning the applicant.
- A "Notice to the Applicant" must be given to all applicants that a report(s) will be ordered concerning their past credit history and any other pertinent information.
 - Consumer reporting agencies include credit agencies, Equifax, Medical Information Bureau, etc.

Fair Credit Reporting Act

- When an applicant is denied coverage due to information obtained from a third party source, the applicant will be informed of the source.
- Insurer must permit an applicant to refute any adverse information.
- Applicant can obtain a copy of report if declined.
- If the applicant feels information is incorrect, the applicant can send a brief statement to reporting agency with correct information.

Do Not Call List

- Created by Telephone Consumer Protection Act (TCPA) and Federal Trade Commission (FTC)
 - Commercial telemarketers are not allowed to call if number is on the registry, subject to the following exceptions:
 - Calls from organizations with which there is established business
 - Calls when written permission has been given
 - Calls that are not commercial
 - Calls that do not include unsolicited advertisements
 - Call by or on behalf of tax-exempt, nonprofit organizations

Gramm-Leach-Bliley Act (GLBA)

- **Consumer**—An individual who obtains, from a financial institution, financial products or services which are to be used primarily for personal, family, or household purposes; also, the legal representative of such an individual
- **Customer**—A consumer that has developed an ongoing relationship with a financial institution
 - Customers must be given an initial and annual privacy notice.

© 2015 Kaplan University School of Professional and Continuing Education 52

Gramm-Leach-Bliley Act (GLBA)

- Privacy notices must explain:
 - what information the company gathers about the customer;
 - where this information is shared; and
 - how the company safeguards that information.
- The initial privacy notice must be given to the customer no later than when the customer relationship begins.

© 2015 Kaplan University School of Professional and Continuing Education 53

Gramm-Leach-Bliley Act (GLBA)

- *Consumers* must be allowed to opt out of the institution's disclosure of nonpublic information to nonaffiliated third parties.
- In addition, *customers* must be allowed to opt out of the institution's disclosure of nonpublic information to affiliated third parties.
 - The **Fair Credit Reporting Act** is responsible for the 'opt-out' opportunity, but the privacy notice must inform the customer of this right under the GLBA.
 - The customer cannot opt-out when the information is legally required to be disclosed.

© 2015 Kaplan University School of Professional and Continuing Education 54

Pennsylvania Laws and Regulations

Applicable to Life Insurance Only

© 2015 Kaplan University School of Professional and Continuing Education 55

Life Insurance Disclosures

- Purpose
 - To protect purchaser from misrepresentation, unfair comparison, and deceptive or misleading sales methods
 - Intended to provide prospective clients with statement containing pertinent information regarding policy being solicited
- Disclosure statement
 - Document which describes purpose and importance of disclosure and significant elements of policy and riders being offered

© 2015 Kaplan University School of Professional and Continuing Education 56

Life Insurance Disclosures

- Disclosure statement (continued)
 - Information about basic policy, rider, or supplemental benefit built into policy, such as a descriptive title (e.g., whole life, 20-year decreasing term, endowment at age 65)
 - Amount of coverage and benefits offered including face amount, retirement income, and cash surrender value
 - Premiums
 - Dividends payable
 - Policy illustrations must clearly display fact that values shown are not guaranteed

© 2015 Kaplan University School of Professional and Continuing Education 57

Life Insurance Disclosures

- Cost disclosures
 - Provides purchaser of life insurance a way to make cost comparisons between same type of policies with same premium payment period and pattern
- Surrender Comparison Index Disclosure
 - Used to compare costs
 - Producer must certify disclosure was given during policy delivery or earlier
 - Insurer must keep certification for three years

© 2015 Kaplan University School of Professional and Continuing Education 58

Replacement of Life Insurance

- A replacement is a transaction in which a new life insurance policy is to be purchased, and it is known by producer or insurer that existing insurance is to be:
 - lapsed or surrendered;
 - pledged as collateral or borrowed against;
 - converted to reduced paid-up;
 - continued as extended term;
 - reissued with reduced cash value; or
 - converted so that amount or period of coverage is reduced.

© 2015 Kaplan University School of Professional and Continuing Education 59

Replacement of Life Insurance

- When replacement is involved, the insurer must provide a written comparison of policy terms, conditions, and benefits within five working days.
- Insurers must provide a Buyer's Guide to prospective purchasers prior to accepting an application for life insurance.

© 2015 Kaplan University School of Professional and Continuing Education 60

Replacement of Life Insurance

- With regard to replacement, producers must:
 - determine if transaction will involve replacement of existing life insurance or an existing annuity;
 - obtain written statement signed by applicant that applicant understands replacement is taking place;
 - provide *Notice Regarding Replacement of Life Insurance and Annuities* signed by both producer and applicant;
 - secure a list of all existing policies to be replaced; and
 - leave copies of all sales proposals or other sales material, including a copy of Notice Regarding Replacement, with applicant.

Replacement of Life Insurance

- Insurers must:
 - provide 20-day free look;
 - require signed statement acknowledging replacement;
 - require *Notice to the Applicant* when replacement is involved;
 - provide *Comparative Information Forms*;
 - maintain files of client records for three years after end of relationship; and
 - keep records of their dealing for three years (both replacing and conserving insurer).

Sales Practices

- Life insurance company, producer, solicitor, or other representative may not:
 - infer that by purchasing life insurance policy, prospect will acquire stock ownership interest or status in said insurance company;
 - imply that policy was sold by investment department of company; or
 - allude to payment of dividends (unless specifically provided in contract) or special treatment from insurer.

Separate Accounts

- Separate accounts are established in connection with variable life contracts and variable annuities.
 - Does not include the insurer’s general account
- Variable products’ applicants must be provided with an investment policy statement of the separate account.
- Insurers and producers must adopt suitability standards regarding variable product recommendations.

Policy Loans

- Policyholder may borrow against cash value of life insurance contract after policy has been in force for three full years.
- Insurer has right to defer granting of loan for up to six months (delay clause).
- Policy may terminate if loan indebtedness equals or exceeds loan value.
- Insurer will deduct any outstanding indebtedness from the death benefit when insured dies.
- Maximum fixed loan interest rate is 8%.

Policy Delivery

- If life or health policy or annuity is delivered by hand, a delivery receipt must be used and must state the date policy or annuity was received by policyholder.
 - Receipt date is date the policyholder and producer sign delivery receipt.
 - Receipt date begins free-look period.
- If policy or annuity is mailed, certificate of mailing is adequate proof of delivery.

Insurable Interest

- For people related by blood or law, **insurable interest** means an interest engendered by love and affection.
- In other cases, insurable interest means a lawful economic interest in having the life of the insured continue, as distinguished from an interest that would arise only by the insured's death.
- For life insurance, insurable interest need only exist at the time of application.

Free Look

- 10 days—Individual life insurance
- 45 days—Individual policies issued as replacements, issued by the same insurer
- 20 days—Individual policies issued as replacements, issued by a different insurer

Group Life Conversion

- Notice of conversion must be given at least 15 days before expiration date of group coverage.
 - If notice is not given, an additional period of 15 days must be granted, but does not extend beyond 60 days after expiration date of coverage.

Accelerated (Living) Benefit

- Accelerated benefits may be paid if:
 - insured's life expectancy is six months or less, or 12 months or less;
 - insured has suffered total and permanent disability; or
 - insured is confined to a health care facility and is expected to remain in facility for rest of life.
- Policy must contain clear statement that death benefit and any accumulation values and cash values will be reduced if accelerated death benefit is paid.

© 2015 Kaplan University School of Professional and Continuing Education 70

Policy Illustrations

- Producer may not alter, change, or modify the results of life insurance or annuity illustration.
- Life insurance and annuity illustrations are not part of the policy.
- Insurer or producer may not:
 - state or imply that dividends are guaranteed;
 - use incomplete or misleading illustration; or
 - use terms *vanish* or *vanishing premium* to imply policy may become "paid up," where nonguaranteed elements are used to pay all or a portion of future premiums.

© 2015 Kaplan University School of Professional and Continuing Education 71

Policy Illustrations

- Illustrations must have the following:
 - Date of preparation and pagination
 - Name of the insurer
 - Name and address of the producer, if applicable
 - Generic product name and form number
 - Name, age, and gender of insured
 - Underwriting class of insured
 - Initial death benefit
 - Dividend option used, if applicable

© 2015 Kaplan University School of Professional and Continuing Education 72

Reinstatement

- Life insurance policies must have minimum of three years to reinstate.
- Three-year time period starts from last premium paid.

General Topics

- Retained asset account
 - A retained asset account is a life settlement option available to beneficiaries at the death of the insured. The beneficiary has the option to have the death benefit placed in this account with the life insurer. The beneficiary will receive interest on the account, and have access to the money via check-writing privileges.
- Return of premium (ROP) term life insurance
 - Return of premium term policies will return all or a part of the premium paid for the policy if the insured is still alive at the end of the policy term. The premium for the ROP term policy will be higher than a comparable level term policy.

Viatical Settlements

- A viatical settlement contract is a written agreement between viatical settlement provider and life insurance policyowner.
 - Policyowner is paid an amount less than policy's death benefit in exchange for assigning, transferring, sale, or ownership of policy to the provider.

Viatical Settlements

- Viator
 - The original owner of a life insurance policy who enters into a viatical settlement contract
- Viatical settlement provider
 - Person, other than the viator-owner, who enters into viatical settlement contract
- Viatical settlement broker
 - Person, who on behalf of a viator-owner, negotiates settlements for a fee, commission, or other consideration

© 2015 Kaplan University School of Professional and Continuing Education 76

Viatical Settlements

- Chronically ill
 - Unable to perform at least two activities of daily living (eating, toileting, transferring, bathing, dressing, or continence) or requiring substantial supervision to protect oneself from threats to health and safety due to severe cognitive impairment
- Terminally ill
 - To have an illness that can reasonably be expected to result in death in 24 months or less

© 2015 Kaplan University School of Professional and Continuing Education 77

Viatical Settlements

- Required disclosures
 - Viator has right to rescind contract for 30 days from date of contract and for at least 15 calendar days from date of receipt of proceeds.
 - Funds must be sent within 3 business days after transfer of ownership of policy.
 - Possible alternatives to viatical settlement
 - Some or all of proceeds may be taxable
 - May adversely affect eligibility for Medicaid

© 2015 Kaplan University School of Professional and Continuing Education 78

Variable Annuities

- Annual Statement to policyholders
 - Company must mail an annual statement to the contract holder.
 - Statement must include the number of accumulation units and the value of account.
 - Statement must be mailed on a fixed date annually (usually anniversary date of annuity).

Suitability of Annuities

- When recommending purchase or exchange of an annuity, insurer or producer must have reasonable grounds for believing recommendation is suitable for consumer based on facts disclosed by the consumer
- Suitability information includes:
 - financial status
 - tax status; and
 - investment objectives.

Variable Annuities

- Recordkeeping requirements
 - Information regarding recommendations that were basis for insurance transactions must be kept for 5 years.

Pennsylvania Laws and Regulations

Applicable to Accident and Health Insurance Only

© 2015 Kaplan University School of Professional and Continuing Education 82

Health Insurance Replacements

- Producer must give applicant *Notice to Applicant Regarding Replacement of Accident and Sickness Insurance* at time of application.

© 2015 Kaplan University School of Professional and Continuing Education 83

Health Insurance Standards

- Terms of renewability
 - Policies must include renewal, continuation, or nonrenewal provision.
- Outlines of coverage
 - Must be delivered with policy; briefly describes terms and benefits of contract
- Condition of eligibility
 - May include insured, spouse, and dependent children

© 2015 Kaplan University School of Professional and Continuing Education 84

Preexisting Conditions

- The Federal *Affordable Care Act* (a.k.a. *ACA* or *PPACA*) eliminated preexisting condition exclusions for medical expense policies.
- ACA preexisting condition requirements do not apply to the following health insurance policies:
 - Disability income insurance
 - Medicare supplements
 - Long-term care insurance
 - Accident only policies

Preexisting Conditions

- In PA, group long-term disability policies may not define a preexisting condition more restrictively than a disease or physical condition caused by illness or injury for which medical advice or treatment has been received within 90 days immediately prior to becoming covered under the group contract.
 - Preexisting conditions must be covered after the person has been covered for more than 12 months under the group.

Preexisting Conditions

- Blanket or group student accident and sickness insurance and group mortgage disability insurance may not include preexisting condition exclusions.

Health Insurance Standards

- 30 days—Maximum probationary period in PA
- 10 days—Free look (except Medicare supplement and long-term care insurance)
- Adopted children coverage
 - Must be treated same as any other dependent under health insurance contract

© 2015 Kaplan University School of Professional and Continuing Education 88

Health Insurance Standards

- Coverage of mentally or physically handicapped child may continue past limiting age as long as:
 - policy remains in force;
 - incapacity continues; and
 - dependent remains chiefly financially dependent on policyholder (parents).
- Proof of incapacity must be received by insurer within 31 days of expiration date.

© 2015 Kaplan University School of Professional and Continuing Education 89

Mental Illness

- Group health insurance policies issued to groups of 50 or more employees must provide coverage for mental illnesses.
 - Coverage for mental illnesses must include at least 30 inpatient and 60 outpatient days annually.
 - There must be no difference in the annual dollar limits in coverage for mental illnesses and any other illnesses.
 - Cost-sharing arrangements, such as deductibles and co-payments, for coverage of serious mental illnesses may not prohibit access to care.

© 2015 Kaplan University School of Professional and Continuing Education 90

Group Health Insurance

- Conversion privilege
 - Group policy providing hospital, surgical, or medical expense benefits on expense-incurred basis must include option for conversion of coverage.
 - Individual must have been continuously insured by group policy for at least three months.
 - Does not apply to indemnity, specific disease, or accidental injury-only policies

Group Health Insurance

- Conversion privilege (continued)
 - No evidence of insurability is required.
 - Application and first premium must be made within 31 days after group coverage terminates.
 - Premium for the individual policy must be at the insurer's customary rate for the person's age and class of risk.
 - Effective date of converted policy will be day after group coverage terminates.

Group Health Insurance

- Conversion privilege (continued)
 - All certificate holders must be given written notice of conversion privilege within 15 days before or after date of termination of group coverage.
 - If notice is given more than 15 days, but less than 90 days after termination of coverage, conversion privilege is extended for 15 days after actual notice is given.
 - If termination notice is not given within 90 days, right to conversion privilege expires.

Health Policy Provisions

- PA health policy provisions follow the NAIC model law discussed in the Kaplan license exam manual and online course, with the following exception:
 - **Time limit on certain defenses**—After **three** years from the date of issue of this policy, no misstatements, except fraudulent misstatements made by the applicant in the application, shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such three-year period.

Alcohol Abuse and Dependency

- All group health policies providing hospital or medical/surgical coverage must provide coverage for alcohol dependency and abuse.
- All costs are subject to deductibles, co-payments, and coinsurance, but they may not be less favorable than other forms of coverage.

Cancer Benefits

- Individual and group health policies, and HMOs providing hospital or medical/surgical coverage, must provide coverage benefits for:
 - cancer chemotherapy;
 - cancer hormone treatments; and
 - other FDA-approved treatments.
- Treatments may be performed in a physician's office, outpatient or inpatient department of a hospital, or any other medically appropriate treatment setting.

Mammography Coverage

- Minimum coverage required shall include all costs associated with an annual mammogram for women 40 or older.
- Minimum coverage must also include any mammogram based on a physician's recommendation for women under 40.

Eligible Family Members

- Insured, spouse, and children of insured (or spouse) not to exceed age 19
 - Note: The federal Affordable Care Act allows coverage for children to age 26.

Marketing and Advertising

- Advertising benefits where payment is conditional on hospital confinement must not use phrases such as *tax free*, *extra cash*, *extra income*, or *extra pay* as it may mislead public into believing they can profit from being hospitalized.
- Specified illness policy advertisements must clearly and conspicuously state its limits in language such as, "THIS IS A LIMITED POLICY."

Marketing and Advertising

- Exceptions, reductions, and limitations
 - When advertisement refers to specific dollar amounts, time periods, costs, losses or benefits, or any reductions or limitations that affect the benefits, they must be clearly revealed.
 - Waiting, elimination, probationary, or other time periods must be disclosed.

© 2015 Kaplan University School of Professional and Continuing Education 100

ERISA

- Employee Retirement and Income Security of Act of 1974 (ERISA)
 - Intended to accomplish pension equality
 - Also protects group insurance plan participants
 - Includes stringent reporting and disclosure requirements for establishing and maintaining group health insurance and other qualified plans
 - Summary plan descriptions must be filed with Department of Labor.
 - An annual financial report must be filed with the IRS.

© 2015 Kaplan University School of Professional and Continuing Education 101

ERISA

- Includes stringent reporting (continued)
 - Requirements for other qualified plans include maintaining items such as:
 - legal documentation of the trust agreement;
 - plan instrument;
 - plan description;
 - plan amendments;
 - claim and benefit denials;
 - enrollment forms;
 - certificates of participation;
 - annual statements;
 - plan funding; and
 - administrative records.

© 2015 Kaplan University School of Professional and Continuing Education 102

COBRA – Federal Continuation

- Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)
- Group medical and dental only
- Applies to loss of group coverage for any reason, except termination due to gross misconduct

COBRA – Federal Continuation

- Notification period—14 days
- Decision period—60 days
- Continuation period
 - 18 months for terminated employee
 - 29 months for disabled employee
 - 36 months for dependents of deceased employee

COBRA – Federal Continuation

- Applies to employers with 20 or more employees to provide former employees and their families a **continuation of benefits under the employer’s group health insurance plan**
 - Same group coverage that the employee had as a covered employee
- A qualified beneficiary may continue to participate in the group insurance plan by paying 102% of the actual group rate to the sponsor.

HIPAA

- Health Insurance Portability and Accountability Act (HIPAA)
 - Took effect July 1, 1997
 - Ensures **portability of group insurance coverage**
 - Includes various mandated benefits that affect small employers, the self-employed, pregnant women, and the mentally ill
 - Designed to minimize preexisting conditions exclusions
 - Note: The 2010 federal Affordable Care Act (ACA) eliminated preexisting condition exclusions for plans affected by ACA. Affordable Care Act is discussed later in this section.

HIPAA – Portability

- Under HIPAA, a person changing jobs is eligible for the new employer’s medical plan without losing coverage for preexisting conditions if:
 - the person had continuous, creditable coverage for **at least 12 months**; and
 - there is no more than a **63-day gap**.
- An individual with group health insurance who leaves to become self-employed cannot be denied coverage.

HIPAA – Portability

- Insurers can require **certificate of prior creditable coverage**.
- If creditable coverage has not been obtained:
 - group plans cannot impose more than a 12-month preexisting conditions exclusion for a person who sought medical advice, diagnosis, or treatment within the previous six months; and
 - this exclusion cannot be applied in the case of newborns, adopted children, or pregnancies existing on the effective date of coverage.

HIPAA – Privacy

- HIPAA imposes specific requirements on health care providers, insurers, and intermediaries with respect to the privacy of the insureds' health and medical information.
- The applicant must be given notice of:
 - the insurer's privacy practices;
 - the applicant's rights to maintain privacy; and
 - the applicant's opportunity to opt-out.
- The intermediary must provide the applicant with the *Notice of Insurance Information Practices*.

Affordable Care Act (ACA)

- **Individual Mandate**—Beginning in 2014, most U.S. citizens and legal residents must have qualifying health coverage, or pay a tax penalty.
- **Tax penalty** for not having coverage is greater of \$695 per year up to maximum of \$2,085 per family or 2.5% of household income.
 - Penalty phased in according to following schedule:
 - 2015—\$325 or 2.0% of taxable income
 - 2016—\$695 or 2.5% of taxable income

Affordable Care Act (ACA)

- States were given the choice of setting up a state-based American Health Benefit Exchange (marketplace) or offering coverage through the Federal exchange.
- Group health plans and health insurance issuers that cover dependent children must make coverage available for adult children of an insured up to age 26.

Affordable Care Act (ACA)

- **Essential Benefits** must be included under all ACA qualified plans with no lifetime or annual dollar limits.
 - Insurers can put lifetime and annual dollar limits on health care services that are not *essential health benefits*.

© 2015 Kaplan University School of Professional and Continuing Education 112

Affordable Care Act (ACA)

Essential Health Benefits

• Emergency services	• Pediatric care
• Hospitalizations	• Prescription drugs
• Laboratory services	• Preventive care
• Maternity care	• Rehabilitative and habilitative (helping maintain daily functioning) services
• Mental health and substance abuse treatment	• Vision and dental care screening for children
• Outpatient or ambulatory care	

© 2015 Kaplan University School of Professional and Continuing Education 113

Affordable Care Act (ACA)

- *Health Insurance Marketplace* has four levels of coverage (metal tiers).
 - *Bronze plans* cover 60% of medical expenses.
 - *Silver plans* cover 70% of medical expenses.
 - *Gold plans* cover 80% of medical expenses.
 - *Platinum plans* cover 90% of medical expenses.
- **Appeal process**
 - Consumers can appeal insurance company decisions to an independent reviewer.

© 2015 Kaplan University School of Professional and Continuing Education 114

Affordable Care Act (ACA)

- Preexisting conditions
 - Insurers are no longer able to deny coverage to people with preexisting conditions or charge them higher premiums.
- Free preventive care and annual wellness visits
 - Certain adult and child preventative care is covered with no out-of-pocket costs.

Disability Income Insurance

- A policy which provides periodic payments, weekly or monthly, for a specified period during a period of disability
- Maximum elimination periods
 - 90 days for benefit periods of one year or less
 - 180 days for benefit periods of one to two years
 - 365 days for benefit periods of two years or more
- Minimum benefit period is six months.
- Disability payments after age 62 must be at least 50% of amounts payable prior to age 62.

Disability Income Insurance

- Total disability
 - First 24 months
 - Inability to perform all of the substantial and material duties of an insured's own regular occupation
 - After 24 months
 - Inability to perform all of the substantial and material duties of any occupation for which insured is reasonably suited by reason of education, training, or experience.

Disability Income Insurance

- Partial disability
 - Person's inability to perform one or more (but not all) of major, important or essential duties of employment or occupation
 - May be related to percentage of time worked, specific number of hours, or combination
 - When policy provides total and partial disability benefits, only one elimination period may be required.

© 2015 Kaplan University School of Professional and Continuing Education 118

Disability Income Insurance

- Residual disability
 - Must be defined in relation to reduction in earnings
 - May be related to being unable to perform either some or all duties
 - May require qualification period
 - Insured must be continuously totally disabled before receiving benefits.
 - Period may be longer than elimination period for total disability.

© 2015 Kaplan University School of Professional and Continuing Education 119

Disability Income Insurance

- Relation of earnings to insurance
 - If monthly benefit exceeds insured's monthly pre-disability earnings, benefit will be reduced proportionately.

© 2015 Kaplan University School of Professional and Continuing Education 120

Long-Term Care Insurance

- Marketing Standards
 - Selling excessive coverage, high-pressure tactics, and twisting (misleading or incomplete representations or fraudulent comparisons) in an attempt to sell an LTC policy are prohibited practices.
 - Companies must train their producers on proper marketing standards and procedures to ensure sales presentations and product comparisons will be fair and accurate.

Long-Term Care Insurance

- Outline of Coverage must be provided by the time of application to each person applying for a LTC policy.
- Outline of coverage includes a description of benefits, exclusions, reductions, and limitations contained in policy.
- Shopper's guide must be provided to each prospect, also.

Long-Term Care Insurance

- Suitability—Reasonable efforts must be made to determine that the purchase of an LTC policy is suitable for the individual.
 - Producers are required to list all health policies they sold to applicant that are in force, and those that were sold in last five years that are no longer in force.
 - If replacement is involved, a *Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-Term Care Insurance* must be signed by the applicant and the producer.

Long-Term Care Insurance

- Inflation protection
 - Insurers must offer inflation protection of at least 5% compounded annually.
 - Insured is not required to purchase inflation protection.
 - *Outline of Coverage* must chart benefits with and without inflation protection.
- LTC policies issued to individuals must be either guaranteed renewable or noncancelable.

Long-Term Care Insurance

- Unintentional lapse—No policy may be issued without applicant providing insurer with the name of at least one person in addition to applicant who will receive notification of lapse or termination.
 - Applicant may sign written waiver reflecting desire not to designate a person to receive notification.
 - Notices of nonpayment and pending lapse must be mailed no sooner than 30 days after payment is owed and at least 30 days prior to lapse or termination.
 - Policies must contain reinstatement provision in event a lapse occurs and insurer is provided proof of cognitive impairment or functional incapacity.

Long-Term Care Insurance

- Required disclosure provisions
 - Riders and endorsements changed or added after issue must be agreed to in writing by the insured.
 - When benefits are payable on a “reasonable and customary” or similar basis, the terms must be defined.
 - Limitations or conditions on eligibility for benefits must be described in a separate paragraph titled *Limitations or Conditions on Eligibility for Benefits*.
 - Brief description of policy must appear on first page at the top or bottom. Policy must be classified as “qualified” or “nonqualified.”

Long-Term Care Insurance

- Permitted compensation arrangements
 - First-year commissions may not be greater than 50% of the first year premium.
 - Renewal commissions provided for a minimum of five years may not exceed 10% of the renewal premium.
 - If replacement is involved, compensation may not exceed renewal commission paid by replacing insurer.

Long-Term Care Insurance

- Preexisting conditions
 - No LTC policy may include a preexisting condition exclusion provision of more than six months, nor exclude coverage for any preexisting conditions except those occurring during six months from effective date.
 - Post-claims underwriting is prohibited. Insurer must determine applicant's acceptability as an insured before policy is issued.
- 30 day—Free look

Long-Term Care Insurance

- **Nonqualified policy** benefit triggers
 - Eligibility for payment of benefits may not be more restrictive than requiring either:
 - the inability to perform up to *three* activities of daily living; or
 - cognitive impairment.
 - Activities of daily living include bathing, continence, dressing, eating, toileting, and transferring.

Long-Term Care Insurance

- **Qualified policy** benefit triggers
 - Payment of benefits is determined by:
 - the insured's inability to perform at least *two* activities of daily living for an expected period of at least 90 days due to loss of functional capacity; or
 - cognitive impairment.

© 2015 Kaplan University School of Professional and Continuing Education 130

Long-Term Care Insurance

- Nonforfeiture benefits must be offered by LTC insurer.
- If offer is rejected by insured, insurer must provide contingent benefit upon lapse.
 - Contingent benefit will be triggered if insurer increases premium to a specified percentage over insured's initial premium at policy issue, and policy lapses within 120 days of due date of increased premium.
 - Policyholders must be notified at least 30 days prior to due date of increased premium.

© 2015 Kaplan University School of Professional and Continuing Education 131

Long-Term Care Insurance

- Nonforfeiture benefits—Contingent benefit upon lapse (continued)
 - On or before the effective date of a substantial premium increase, the insurer must:
 - offer to reduce policy benefits so premium is not increased;
 - offer to convert coverage to a paid-up status with a shortened benefit period; and
 - notify policyholder that a default or lapse during the 120-day period after premium increase will be considered election of offer to convert coverage to a paid-up status.

© 2015 Kaplan University School of Professional and Continuing Education 132

Long-Term Care Insurance

- Conversion and continuation
 - Group long-term care insurance must provide covered individuals with basis for continuation or conversion of coverage.
 - Coverage must be continued under existing group policy when it would otherwise terminate, subject only to continued timely payment of premium when due.
 - Coverage must be converted (without evidence of insurability) for any insured who has been covered under group policy for at least six months.
 - Converted policy must be an individual LTC policy that provides benefits identical to, substantially equivalent to, or in excess of those provided under group policy.

Long-Term Care Insurance

- Penalties—Insurers or producers who violate LTC laws or regulations may be subject to civil penalties of:
 - up to three times the amount of any commissions paid for each policy involved in the violation; or
 - \$10,000, whichever is greater.

Long-Term Care Insurance

- Shopper's guide
 - Long-term care insurance shopper's guide in format developed by National Association of Insurance Commissioners (NAIC), or guide developed and/or approved by Commissioner, must be provided to all prospective applicants of a long-term care insurance policy or certificate.

Medicare Supplement Policies

- **Open enrollment**—Insurer may not deny or limit issuing a Medicare supplement policy if an applicant applies within six months of enrolling in Medicare Part B.
 - If applicant has had continuous creditable coverage for at least six months, issuer may not exclude benefits based on preexisting condition.
 - If applicant has had creditable coverage for less than six months, insurer must reduce the preexisting condition exclusion period by amount of time applicant did have creditable coverage.

© 2015 Kaplan University School of Professional and Continuing Education 136

Medicare Supplement Policies

- **Guaranteed issue**—*Eligible persons* had prior group health coverage or Medicare Advantage and applied for a Medicare supplement within 63 days after termination date of prior coverage.
 - For eligible persons, Medicare supplement insurers may not:
 - deny issuance of Medicare supplement coverage;
 - exclude benefits based on preexisting conditions; or
 - discriminate in price of supplement because of health status, claims experience, receipt of health care, or medical condition.

© 2015 Kaplan University School of Professional and Continuing Education 137

Medicare Supplement Policies

- **Permitted compensation arrangements**
 - First-year commission may not exceed 200% of commission paid for selling or servicing policy in second year.
 - Commission in following years must be same as in second year and must be provided for at least five renewal years.
 - Compensation for replacing an existing Medicare supplement policy may not exceed renewal compensation normally paid by replacing insurer.

© 2015 Kaplan University School of Professional and Continuing Education 138

Medicare Supplement Policies

- 30 day free look
- Medicare supplement Buyer's Guide, and an *Outline of Coverage*:
 - must be delivered at time of application; and
 - acknowledgment of receipt must be obtained.

Medicare Supplement Policies

- Replacement requirements
 - Application forms must inquire about other Medicare supplement coverage.
 - If replacement, insurer or agent must give applicant Notice Regarding Replacement.
 - Must be given prior to policy delivery
 - Must be signed by agent and applicant
 - Signed copy must be left with applicant
 - Additional copy must be returned to insurer

Medicare Supplement Policies

- Replacement requirements (continued)
 - Producer must also verify if prospect has Medicare Advantage, in which case, he or she should not purchase a Medicare supplement.
 - Replacing insurer must waive time periods for preexisting conditions, waiting periods, elimination periods, and probationary periods in new Medicare supplement.
 - If the existing policy was in place for at least six months, replacing policy may not impose another time period for aforementioned.

Medicare Supplement Policies

- Standards for marketing
 - Established by insurers so that comparison of policies are fair and accurate
 - Ensures that excessive insurance isn't sold or issued
 - Medicare supplement advertisements intended for use in Pennsylvania must be filed with the Insurance Commissioner for review and approval.

© 2015 Kaplan University School of Professional and Continuing Education 142

Medicare Supplement Policies

- Appropriateness of recommended purchase
 - A sale of Medicare supplement coverage that will provide an individual with more than one Medicare supplement policy is prohibited.
 - A Medicare supplement policy may not be issued to an individual enrolled in Medicare Part C (Medicare Advantage) unless the effective date of coverage is after the termination date of the individual's Part C coverage.

© 2015 Kaplan University School of Professional and Continuing Education 143

Specified Illness/Dread Disease

- Outline of coverage must be provided, and include the following:
 - Type of coverage must be identified in title
 - A statement explaining the restricted nature of the coverage (e.g., cancer only, heart disease, etc.)
 - A brief specific description of policy benefits, restrictions, and exceptions
 - A description of terms and conditions of renewability, and any rights of cancellation reserved to insured

© 2015 Kaplan University School of Professional and Continuing Education 144

Ethics

© 2015 Kaplan University School of Professional and Continuing Education 145

Introduction

- **Ethical conduct**—Conduct that a reasonable person is expected to do under any circumstances
 - Ethical standards of business include “have-to” legal requirements and “choose-to” ethical standards.
 - Code of ethics helps producers avoid controversy, misunderstandings, and legal entanglements.
 - Increases personal efficiency as an insurance producer
 - Increases opportunities for renewals and referrals

© 2015 Kaplan University School of Professional and Continuing Education 146

Introduction

- **Overview of Ethics and the Insurance Producer**
 - Insurance producers have ethical responsibilities to insurers, policyowners, the public, and the state.
 - Duties of an insurance producer to the insurer are established by the concept of *agency*. This concept is tangibly represented by the agency contract, which both parties agree to and sign.
 - As the insurer’s producer, the producer owes an insurer honesty, good faith, and loyalty.
 - As the insurer’s representative, the producer’s day-to-day activities are a reflection of the insurer’s image within the community.

© 2015 Kaplan University School of Professional and Continuing Education 147

Introduction

- Compliance and market conduct
 - Conducting business in accordance with current rules and laws set by government regulatory agencies and courts
 - Applies to both insurance producers and companies
 - “Laws and regulations tell us what we *must* do.”

© 2015 Kaplan University School of Professional and Continuing Education 148

Introduction

- Ethics are standards of conduct and moral judgment.
 - “Ethics are about what we *should* do.”
 - Characteristics of an ethical insurance producer are the following:
 - Honesty
 - Integrity
 - Loyalty
 - Fairness
 - Compassion
 - Respect for others
 - Personal responsibility
 - Accountability

© 2015 Kaplan University School of Professional and Continuing Education 149

Introduction

- Market conduct is a combination of ethics and compliance.
 - Refers to how insurance companies and producers conduct themselves in accordance with ethical standards and compliance with insurance rules and law
 - Market conduct is synonymous with professional behavior.

© 2015 Kaplan University School of Professional and Continuing Education 150

Agency

- *Agency* describes the relationship between the producer and the insurer and has the following key principles:
 - The acts of the producer (within the scope of the producer’s authority) are the acts of the principal.
 - A contract completed by a producer on behalf of the principal is a contract of the principal.
 - Payments made to a producer on behalf of the principal are payments to the principal.
 - Knowledge of the producer regarding business of the principal is presumed to be knowledge of the principal.

Agency

- The *agency contract* appoints a producer to act on the insurer’s behalf, and identifies the agent’s authority.
- Appointed producers (agents) have a fiduciary relationship with the insurer.
 - A *fiduciary* is an individual whose position and responsibilities involve a high degree of trust and confidence.

Agency

- Authority—Through appointment, producer generally is given power and express authority to act for insurer by:
 - soliciting applications for coverage;
 - describing coverage and policies to prospects and applicants, and explaining how such policies can be purchased;
 - collecting premiums (or, in some cases, only initial premiums); and
 - providing service to prospects and the insurer’s policyholders.

Producer as Fiduciary

- Loyalty to insurer
 - Producer must act in insurer’s best interest in every matter involving insurer’s business.
- Care and skill
 - Producer has duty to act with utmost care and skill.
 - Sometimes, producer may have to refer business to others who are more qualified.
- Full disclosure
 - Producer is obligated to disclose all information that may affect insurer.
 - Most significant during application and claims-handling process

© 2015 Kaplan University School of Professional and Continuing Education 154

Producer as Fiduciary

- Prompt action and follow-up
 - Producer is responsible for transmitting completed applications and notice of premium receipts as quickly as possible.
- Handling premiums
 - Producer has fiduciary duty to account for all funds received in connection with insurer’s business.
 - It is considered unethical to delay or withhold premium payment.

© 2015 Kaplan University School of Professional and Continuing Education 155

Producer as Fiduciary

- Avoiding conflicts of interest
 - Producer with exclusive contract cannot serve two principals at the same time.
 - Captive producers may only work with one insurer.
 - A producer has an ethical obligation to inform the insurer about any other related service he provides and receives compensation for (e.g., doing part-time tax preparation).

© 2015 Kaplan University School of Professional and Continuing Education 156

Principal's Responsibility

- Duties of the *principal* to the producer
 - A rule of agency law is that the principal (insurer) is responsible for all of a producer's acts when the producer is acting within the scope of his authority.
 - This responsibility includes fraudulent acts, omissions, and misrepresentations.

Producer's Ethical Responsibility

- Needs selling
 - Selling kinds of policies that best fit prospect's needs and in amount that prospect can afford
 - Involves problem analysis, action planning, product recommendation, and plan implementation
 - Commitments by producer are the following:
 - Obtain and maintain knowledge and skills necessary to perform those tasks
 - Educate prospect or client about products and/or plans that may be implemented on producer's recommendation

Producer's Ethical Responsibility

- Servicing a client includes:
 - educating client before, during, and after sale, ensuring understanding of application and underwriting processes, policy purchased, and any attached riders;
 - treating all information with confidentiality;
 - disclosing all information so that policyowner or applicant can make informed decision;
 - keeping prospect or client informed of any rejection, exclusion, or cancellation of coverage; and
 - showing loyalty to prospects and clients.

Producer's Ethical Responsibility

- The application
 - Primary responsibility is to insurer
 - Ethical duty is to educate prospect about application process, including:
 - why information is required;
 - how it will be evaluated;
 - need for accuracy and honest in answering all questions; and
 - meaning of important terms, such as *waiver of premium*, *automatic premium loan*, *nonforfeiture options*, *policy loans*, and *conditional receipt*.

© 2015 Kaplan University School of Professional and Continuing Education 160

Producer's Ethical Responsibility

- A *conditional receipt* is normally given when applicant pays initial premium at time application for policy is signed.
 - Applicant is covered immediately from date of application (or medical exam), as long as he passes insurer's underwriting requirements.
- Full disclosure
 - Informing prospect or client of all facts involving specific policy or plan in order for the client to make an informed decision

© 2015 Kaplan University School of Professional and Continuing Education 161

Producer's Ethical Responsibility

- Policy delivery
 - Producer's duties include the following:
 - Prompt delivery
 - Review of features and benefits
 - Perform periodic reviews to reassess suitability

© 2015 Kaplan University School of Professional and Continuing Education 162

Producer's Ethical Responsibility

- Complete and honest representation
 - Duty to provide prospect with any details regarding the following:
 - Features and benefits
 - Deductibles
 - Waiting periods
 - Benefit limitations
 - Exclusions
 - Qualification requirements for policy

Unauthorized Insurers

- Only insurers authorized or licensed by state may issue policies.
 - Producer must make sure insurers are authorized to do business in the state.
- State guaranty fund does not cover liabilities of unauthorized insurers.

Unfair Marketing Practices

- **Misrepresentation** is any written or oral statement that does not accurately describe a policy's features, benefits, or coverage.
- It is unlawful to induce a person to forfeit, change, or surrender policies through misleading representations, or misleading comparisons of companies or policies.
 - Includes unintentional misrepresentations

Unfair Marketing Practices

- **Defamation** is false, maliciously critical, or derogatory communication (written or oral) that injures another's reputation, fame, or character.
- **Twisting** is the act of persuading policyowner to drop a policy solely for the purpose of selling another policy with no regard for possible disadvantages to policyowner.
 - Involves misrepresentation by producer to convince policyowner to switch insurance companies and/or policies

© 2015 Kaplan University School of Professional and Continuing Education 166

Unfair Marketing Practices

- **Rebating** occurs if insurance purchaser receives any part of producer's commission or anything else of value as an inducement to purchase policy.
 - Examples of rebating include:
 - offering, paying, or allowing any rebate or other inducement not specified in policy, or any special favor or advantage concerning dividends or other benefits that will accrue, in order to place, negotiate, or renew policy; or
 - offering, paying, or allowing any rebate of any premium on any insurance policy or annuity contract.

© 2015 Kaplan University School of Professional and Continuing Education 167

License Suspension/Termination

- Producer's license can be suspended or terminated for violating marketing ethics.

© 2015 Kaplan University School of Professional and Continuing Education 168



3

Detailed Text

HOW TO USE: All state specific topics in your state's exam content outline law and regulation section are covered in this detailed text. Students are encouraged to read the text for in-depth descriptions of the state's insurance laws and regulations. In addition, some topics are not covered in the Cram Sheets and Class Notes, and are only covered in the Detailed Text.

I. PENNSYLVANIA LAWS AND REGULATIONS APPLICABLE TO ALL LINES OF INSURANCE

A. LICENSING PROCESS [40 P.S. SECS. 310.3 TO .14, .31] Before applying for an insurance producer license, an individual shall satisfactorily complete preexamination education and pass an insurance producer licensing examination.

- 1. Prelicensing education requirements** Before applying for the insurance producer licensing examination, an individual must complete a minimum of 24 credit hours of approved prelicensing courses. At least three of those 24 credit hours must be on ethics. Upon satisfactory completion of such a course, the individual will be issued proof of completion by the course provider and may apply to take an insurance producer licensing examination.
- 2.** All license candidates must submit a completed application for examination indicating the lines of authority for which they want to be licensed, a copy of their approved prelicensing study certificate, and the nonrefundable examination fee prior to taking an insurance producer licensing examination.
- 3. License exam exemptions** The licensing exam and the prelicensing education requirements are not required if the candidate is a(n):
 - business entity;
 - person who possesses the professional designation of Chartered Life Underwriter® (CLU®) and is applying for life or accident and health line of authority;
 - person who possesses the professional designation of Chartered Property and Casualty Underwriter (CPCU®) and is applying for a property, casualty, or accident and health line of authority;
 - person who possesses the professional designation of Certified Insurance Counselor (CIC) and is applying for a life, accident and health, or property and casualty line of authority;
 - person who possesses any other professional designation for which the requirements are waived by the Commissioner;
 - person who is licensed in another state as an insurance producer for the lines of authority for which the person desires to be licensed in Pennsylvania;
 - person whose line of authority is only limited line credit insurance;
 - person who has a line of authority restricted to a limited line;
 - individual whose line of authority will be restricted to domestic mutual fire insurance and will be with an insurer writing only coverage other than insurance on automobiles; and
 - individual whose line of authority will be restricted to fraternal insurance.
- 4. Application for a license** An applicant with a principal place of residence or business in Pennsylvania may apply for a resident insurance producer license. An applicant with a principal place of residence or business outside Pennsylvania may apply for a nonresident insurance producer license. An applicant must submit to the Department:
 - a completed application indicating the lines of authority for which the applicant desires to be licensed;

- the applicant's fingerprints, in order for the Department to receive national criminal history records information from the FBI Criminal Justice Information Services Division;
- documentation verifying that the applicant passed or is exempt from the insurance licensing examination on the lines of authority for which the applicant desires a license; and
- the required license fee and fees for obtaining national criminal history records information.
 - A nonrefundable \$55 fee must accompany an application for a resident insurance producer license.
 - A nonrefundable \$110 fee must accompany an application for a nonresident insurance producer license.
 - A nonrefundable \$165 fee must accompany a late application for license renewal.

5. Business entity application Upon designating one or more individuals licensed as a producer to be responsible for the business entity's compliance with the state's insurance laws and regulations, a business entity may apply to the Department for an insurance producer license for the same lines of authority held by the designated licensees.

6. Qualifications for a license The Department will issue a resident or nonresident insurance producer license, for a period not to exceed two years, to an applicant when the Department determines that the applicant:

- is at least 18 years of age;
- has not committed any act that is prohibited under the state's insurance laws;
- has satisfied the prelicensing education requirements;
- has passed (or is exempt from) the insurance producer licensing examination;
- has paid all applicable fees; and
- possesses the general fitness, competence, and reliability sufficient to satisfy the Department that the applicant is worthy of licensure.

B. TYPES OF LICENSES [40 P.S. SECS. 310.1 to .10, .31]

1. Producer A person may not sell, solicit, or negotiate a contract of insurance in Pennsylvania unless licensed as an insurance producer for the line of authority under which the contract is issued. The following persons are not required to be licensed as insurance producers:

- An insurer
- An employee of an insurer or a rating organization employed by an insurer who is not engaged in the sale, solicitation, or negotiation of insurance contracts, and who inspects, rates, or classifies risks, or supervises the training of insurance producers
- An officer, director, or employee of an insurer or of an insurance producer as long as the individual does not receive a commission on policies written or sold to insure risks residing, located, or to be performed in Pennsylvania and their activities are executive, administrative, managerial, or clerical and are only indirectly related to the sale, solicitation, or negotiation of insurance

- A person who, for no commission
 - secures and furnishes written information for the purpose of group life insurance, group property and casualty insurance, group annuities, group or blanket accident, and health insurance,
 - performs administrative services related to the enrollment of individuals under plans,
 - issues certificates under plans or otherwise assists in administering plans,
 - performs administrative services related to mass marketed property and casualty insurance, or
 - provides risk management services to a business entity
 - An employer, including an association, or the trustees of an employee trust plan and their officers, directors, and employees who are engaged in the administration of an employee benefits program that includes insurance for the benefit of the employer's employees; and they are not compensated by the insurer issuing the insurance policy
 - A person engaged in the advertising of insurance if the person does not sell, solicit, or negotiate insurance for risks residing, located, or to be performed in Pennsylvania; and the advertising is distributed to persons residing both within and outside this state through the use of printed publications or other forms of electronic mass media
 - A salaried full-time employee who counsels or advises his employer on the employer's insurance issues and does not sell or solicit insurance or receive a commission
- 2. Nonresident** An individual who is currently licensed as a resident insurance producer in another state or territory may apply to the Department for a nonresident insurance producer license for the equivalent lines of authority as the individual is licensed in his home state.
- a. Reciprocity** The Department may waive the requirements for a person applying for a nonresident insurance producer license in Pennsylvania that possesses a valid insurance producer license from the person's home state if the person's home state awards nonresident insurance producer licenses to resident licensees of this Commonwealth on the same basis.
 - b. Limited line** After application to the Department, a person licensed as a limited line credit insurance or other type of limited lines producer in the person's home state will receive a nonresident limited lines producer license, granting the same scope of authority as granted under the license issued by the producer's home state.
- 3. Temporary license [40 P.S. Sec. 310.9]** If the Department determines that the issuance of a temporary insurance producer license is in the public interest and that the person requesting the license is worthy to receive a temporary license, the Department may issue a temporary insurance producer license to:

- the surviving spouse or court-appointed personal representative of a resident individual licensee who dies or becomes mentally or physically disabled—the temporary license shall be used by the spouse or representative to operate the insurance business owned by the licensee until
 - the business is sold or transferred,
 - the licensee recovers and returns to the business, or
 - new personnel is trained and licensed to operate the licensee’s business;
 - an owner, partner, or employee of a business entity licensee upon the death or disability of the designated licensee—the temporary license shall be used by the owner, partner, or employee to operate the business entity until
 - the business is sold or transferred, or
 - new personnel is trained, licensed, and designated as the designated licensee;
 - the designee of an individual licensee who enters active service in the armed forces of the United States; or
 - any other person in an extenuating circumstance where the Commissioner deems that the public interest will best be served by the issuance of a temporary license.
- a. **Period of license** The temporary license will be for a period not to exceed 180 days and is not transferable.
 - b. The Department may impose other requirements upon a temporary licensee, including requiring a sponsoring insurer and limiting the lines of authority of a temporary licensee, as deemed necessary to protect insureds and the public.
 - c. The Department may immediately and without notice revoke a temporary license if it is deemed in the public interest.
 - d. A person may not use a temporary insurance license to transact new insurance business. The purpose of the temporary license is to maintain, transfer, or conclude existing business, not to generate new business.
- 4. Managers and exclusive general agents** Except as otherwise provided, no person may act as a manager or exclusive general agent without being licensed as such. Acting as a manager or exclusive general agent without a license is a third degree misdemeanor punishable by a fine of up to \$1,000 per day. In some cases, the fine may be paid by the employing insurer.
- a. The following are not required to be licensed as a manager or exclusive general agent:
 - A licensee whose authority is limited primarily to the production of insurance business with limited underwriting authority
 - A manager or exclusive general agent operating under a management contract or exclusive general agency agreement entered into before December 22, 1965
- 5. Lines of authority** A license may be issued to sell the following types of insurance:
- Property insurance

- Casualty insurance
- Personal lines
- Limited line credit insurance
- Motor vehicle rental
- Limited lines, as determined by the Commissioner
- Life insurance
- Accident and health or sickness insurance
- Variable life and annuity products

C. MAINTENANCE AND DURATION

- 1. Renewal [40 P.S. Sec. 310.8]** Licenses are generally issued for a term of two years. Licenses are renewed every 24 months in the producer's birth month. (Renewal notices are sent approximately 60 days prior to the deadline.) The licensee must remit to the Department a completed renewal form, the required fee, and verification that the licensee has completed the continuing education required. A resident licensee that has not previously submitted fingerprints to the Department must also submit the licensee's fingerprints and the fee in order to permit the Department to receive national criminal history records information from the Federal Bureau of Investigation Criminal Justice Information Services Division.
- 2. Lapses** A licensee who allows a license to lapse by failing to renew in a timely manner, pay the fee required, or complete the continuing education required may within one year of the license renewal date request the Department to reinstate the license. Persons requesting reinstatement of a lapsed license must submit a completed renewal form, the required fee, and verification that the person has completed all required continuing education for the previously licensed and lapsed periods.
 - a.** The Department will reinstate the license retroactively, with the reinstatement effective on the date the license lapsed, if the Department receives a request for reinstatement together with a completed renewal application, payment of the lapsed license fee, and proof of continuing education compliance within 60 days after the license lapsed.
 - b.** The Department will reinstate the license prospectively, with reinstatement effective on the date that the license is reinstated, if the Department receives a request for reinstatement of a lapsed license more than 60 days after the license lapsed.
 - c.** If a person applies for reinstatement more than one year after the lapse date, the person must reapply for the license.
 - d. Extenuating circumstances [40 P.S. Sec. 310.8]** A licensee who is unable to comply with the renewal requirements in a timely manner as a result of military service or other extenuating circumstance may request that the Department waive the continuing education requirements and fee. The request must include sufficient detail and supporting documentation to determine the

necessity of the waiver. If the Department determines that there is good cause for noncompliance, the Department will grant the waiver and permit the licensee to request renewal of the license in accordance with this act.

- 3. Reporting of actions [40 P.S. Sec. 310.78]** A licensee must report to the Department any administrative action taken against the licensee in another jurisdiction or by another governmental agency in Pennsylvania within 30 days of the final disposition of the matter. This report must include a copy of the order, consent order, or other relevant legal documents.
 - a. Criminal conduct reporting** Within 30 days of being charged with criminal conduct, a licensee must report the charges to the Department. The licensee must provide to the Department all of the following within 30 days of their availability to the licensee:
 - A copy of the criminal complaint, information, or indictment
 - A copy of the order resulting from a pretrial hearing, if any
 - A report of the final disposition of the charges
- 4. Assumed names [40 P.S. Sec. 310.7]** An insurance producer license issued by the Department may be issued only in the name of the applicant or business entity. If a licensee is doing business under a fictitious name other than the name appearing on the producer license, the licensee is required to notify the Commissioner in writing prior to use of the fictitious name.
- 5. Address change [40 P.S. Sec. 310.11(19)]** Licensees must notify the Department of any change of address within 30 days.
- 6. Continuing education [40 P.S. Sec. 310.8(b)]** Each licensee is required to complete 24 credit hours of approved continuing education for each two-year license period as a condition for license renewal. A licensee may carry forward excess continuing education credit hours up to a maximum of 24 credit hours from one licensing period to the next. The following shall be exempt from the continuing education requirements:
 - A licensee who was licensed as an agent or broker for a line of authority prior to January 1, 1971, and who has been continuously licensed as an agent, broker, or producer for the line of authority since that time
 - A licensee which is a business entity
 - A licensee who has only a limited line of authority
 - A licensee who has a line of authority limited to restricted fraternal
 - A licensee who has a line of authority restricted to limited line credit insurance if the insurer provided a course of instruction to each individual whose duties will include selling, soliciting, or negotiating the insurance
 - A nonresident licensee who has satisfied the continuing education requirements of the licensee's home state if that state recognizes the satisfaction of its continuing education requirements by a resident licensee satisfying the Pennsylvania requirement—a producer may request an extension in case of military duties or extenuating circumstances

D. DISCIPLINARY ACTIONS

- 1. Cease and desist order [40 P.S. Secs. 310.91, 1171.9]** If, as a result of investigation, the Commissioner has good cause to believe that a person is violating any provision of this act, the Commissioner will send notice of the violation by certified mail to the person believed to be in violation. The notice shall state the time and place for hearing, which shall not be less than 10 days from the date of the notice. At the time and place fixed for the hearing in the notice, the person will have an opportunity to be heard and to show cause why an order should not be made by the Commissioner to cease and desist from acts constituting a violation of this act and why administrative penalties should not be assessed.

 - a.** Upon a determination by hearing that this act has been violated, the Commissioner may issue an order requiring the person to cease and desist from engaging in such violation or, if such violation is a method of unfair competition, the Commissioner may suspend or revoke the person's license.
- 2. Revocation, suspension, nonrenewal, or denial of license [40 P.S. Sec. 310.91]** Upon evidence of a violation of this act, the Department will notify the person of the alleged violation. The notice must specify the nature of the alleged violation and fix a time and place, at least 10 days thereafter, when a hearing on the matter will be held. No person may be excused from testifying or from producing any books, papers, contracts, agreements, or documents at any hearing held by the Commissioner on the ground that the testimony or evidence may tend to incriminate that person. After the hearing or upon failure of the person to appear at the hearing, if a violation of this act is found, the Commissioner may, in addition to any penalty that may be imposed by a court, impose any combination of the following deemed appropriate:

 - Denial, suspension, refusal to renew, or revocation of the license of the person
 - A civil penalty not to exceed \$5,000 for each violation of this act
 - An order to cease and desist
 - Any other conditions the Commissioner deems appropriate
- 3. Revocation, suspension, and nonrenewal of certificates and licenses in the nonresident agent or broker's home state** If a nonresident agent or broker has a license or certificate that is revoked, suspended, or not renewed in the state of domicile, the agent or broker may be subject to revocation, suspension, or nonrenewal in this Commonwealth.
- 4. Civil and administrative fines [40 P.S. Secs. 310.12, .91; 1171.11]** In addition to any penalties imposed pursuant to this act, the court may, in an action filed by the Commissioner, impose the following civil penalties.

 - For each method of unfair competition, act, or practice and in violation of this act that the person knew or reasonably should have known was a violation, a penalty may be imposed of not more than \$5,000 for each violation but not to exceed an aggregate penalty of \$50,000 in any six-month period.

- For each method of unfair competition, act, or practice that the person did not know, nor reasonably should have known, was a violation, a penalty may be imposed of not more than \$1,000 for each violation but not to exceed an aggregate penalty of \$10,000 in any six-month period.
- For each violation of an order issued by the Commissioner while such order is in effect, a penalty may be imposed of not more than \$10,000.
- A licensee who fails to provide a written response within 30 days after receiving a written inquiry from the Department, or who fails to pay all fees due must, after notice from the Department specifying the violation and advising of corrective action to be taken, correct the violation within 15 days of receiving the notice. The Department may assess an administrative fine of no more than \$100 per day per violation if a licensee does not correct the violation within 15 days.

E. COMMISSIONER'S GENERAL DUTIES AND POWERS [40 P.S. SECS. 310.2, 1171.7]

The primary duty of the Insurance Commissioner is to see that insurance laws are properly executed and the public interest is protected by enforcing these laws. For example, the Commissioner of Insurance investigates reports of unfair and deceptive practices. The Commissioner will also have the power to revoke licenses of insurers, adjusters, and producers for just cause. In addition, the Commissioner also has the power to regulate insurers for solvency, approve policy forms, and regulate most insurance premium rates. Other general duties include, but are not limited to, issuing licenses and collecting the appropriate fees; appointing examiners who are delegated the duty of examining insurers; issuing cease and desist orders to insurers, adjusters, and producers for just cause; conducting hearings in connection with the wrongdoing of an insurer or licensee; and reporting illegalities in the insurance business to the state attorney general.

The Commissioner has the power to revoke and suspend licenses, but the attorney general usually prosecutes an individual who breaks insurance laws. Generally, the Commissioner may not be a director, officer, or producer of an insurer. The Commissioner is usually appointed by the governor of the state to a four-year term.

1. The Commissioner will:
 - license insurance producers; and
 - approve and administer, or contract for the overall administration of the preexamination program, preexamination courses of study, insurance producer licensing examinations, and continuing education programs.
2. The Commissioner may:
 - issue rules and regulations to implement and administer the insurance code, but may not change the code itself;
 - secure or require any documents or information, including fingerprints, reasonably necessary to verify the accuracy of information provided on an application;
 - participate with the National Association of Insurance Commissioners (NAIC) in a centralized insurance producer license registry for submitting or obtaining information on insurance producers, including licensing history, lines of authority, and regulatory action;
 - approve forms to be used by individuals and business entities to apply to the Department for an insurance producer license; and
 - approve additional limited lines of authority.

- 3. Producer appointments and disclosures [40 P.S. Sec. 310.71]** An insurance producer may not act on behalf of, or as a representative of, the insurer unless the insurance producer is appointed by the insurer.
- a.** An insurance producer representing an insurance consumer (as opposed to representing an insurance company) must execute a written agreement with the insurance consumer prior to representing or acting on their behalf that:
 - delineates the services to be provided; and
 - provides full and complete disclosure of the fee to be paid to the insurance producer by the insurance consumer.
 - b.** An insurer that appoints an insurance producer must file with the Department a notice of appointment.
 - c. Termination of appointment** Once appointed, an insurance producer remains appointed by an insurer until the insurer terminates the appointment in writing to the insurance producer or until the insurance producer's license is suspended, revoked, or otherwise terminated.
 - d.** An appointment fee of \$15 will be billed annually to the insurer for each producer appointed by the insurer during the preceding calendar year regardless of the length of time the producer held the appointment with the insurer. The appointment fee may be modified by regulation. The fee must be paid in full within 30 days.
 - e.** An insurer must, upon request, certify to the Department the names of all licensees appointed by the insurer.
- 4. Termination of appointments [40 P.S. Sec. 310.71a]** An insurer that terminates an appointment must notify the Department in writing on a form approved by the Department, or through an electronic process approved by the Department, within 30 days following the effective date of the termination.
- a.** If the reason for the termination was a violation of this act or if the insurer had knowledge that the licensee was found to have engaged in any activity prohibited by this act, the insurer must inform the Department in the notification. Upon the written request of the Department, the insurer must provide additional information, documents, records, or other data pertaining to the termination or activity of the producer.
 - b. Copy of notification to be provided to licensee** Within 15 days of making a notification required by this section, an insurer must mail a copy of the notification to the licensee's last known home address by certified mail, return receipt requested, postage prepaid, or by overnight delivery using a nationally recognized carrier.
 - c.** Within 30 days of receiving notification pursuant to this section, a licensee may file written comments concerning the substance of the notification with the

Department. The licensee must simultaneously mail a copy of the comments to the insurer by certified mail, return receipt requested, postage prepaid, or by overnight delivery using a nationally recognized carrier.

- d. An insurer or licensee that fails to report as required under the provisions of this section or that is found to have falsely reported with malice by a court of competent jurisdiction may, after notice and hearing, have its license or certificate of authority suspended or revoked and may have civil penalties imposed against the insurer or licensee in an amount not to exceed \$5,000 for each violation.

5. Regulation of insurer solvency [40 P.S. Secs. 72, 112]

- a. Insurers doing business in Pennsylvania must maintain specified minimum levels of capital stock and surplus. The amounts required vary depending on the line of insurance and how the company is organized.
- b. Every domestic insurer must submit a report of its RBC (risk-based capital) levels to the Commissioner and the NAIC every year by March 1. Domestic insurers must also submit this report upon request to the chief insurance regulatory official in any jurisdiction in which they are authorized to do business.
- c. When a life insurer does not have the net value of all policies in force, after all debts and claims have been accounted for and the required minimum capital has been included, the Commissioner will tell the insurer and its agents to issue no new policies until its funds are equal to its liabilities.

6. Casualty and Surety Rate Regulatory Act [40 P.S. Secs. 1181-1199, 1221-1238]

- a. The purpose of the Casualty and Surety Rate Regulatory Act is to regulate insurance rates to avoid excessive, inadequate, or unfairly discriminatory rates. It helps authorized insurers meet the requirements of insurers in the Commonwealth and regulates agreements made between insurers when setting rates.
- b. Insurers may agree to share insurance provided for applicants who are unable to obtain insurance through ordinary methods. These insurers may agree among themselves to use reasonable rate modifications for this insurance. These agreements and rate modifications are subject to the Commissioner's approval.
- c. The Commissioner will examine every rating organization at least once every five years. The Commissioner may also examine every advisory organization. The organization pays for the costs of the examination.

7. Approval of policy forms [40 P.S. Secs. 510, 776.1-.7, 1181-1199, 1221-1238]

- a. **Form filing and approval** Insurers cannot issue or sell any life, accident, or health insurance policies until the forms have been filed and approved by the

Commissioner. Once forms have been filed, they are considered approved after 30 days unless the Commissioner rejects them. However, the Commissioner may notify the insurer that he is extending this period for another 30 days to continue the review.

- b. Disapproval and appeals** If the Commissioner disapproves a form, he will notify the insurer in writing of the reasons for disapproval. Within 30 days of the mailing of this notice, the insurer may apply for a hearing on the decision. This hearing will be held within 30 days after the Commissioner receives the request.
- c. Penalties** Anyone who issues an insurance policy or contract without the Commissioner's prior approval is guilty of a misdemeanor and, if convicted, must pay a fine of up to \$500. The Commissioner may also suspend or revoke the offender's license, refuse to issue a new license for up to one year, impose a fine of up to \$1,000 for every violation, or some combination of these penalties.

- 8. Insurance company exceeding powers of authority—certificate of authority [40 P.S. Secs. 47a, 420]** Any insurance company that exceeds the powers granted under the certificate of authority shall forfeit and pay to the Commonwealth a fine of \$500 for each and every policy that is issued in violation. If the insurer requests a hearing on this matter, it must be requested within 10 days of notice of violation. This also includes any government-owned insurance company.

F. PRODUCER REGULATION

- 1. Fiduciary responsibility [40 P.S. Sec. 310.96, 31 Pa. Code Ch.37.81]** An insurance producer shall be responsible in a fiduciary capacity for all funds received or collected as an insurance producer and shall not, without the express consent of the insurance entity on whose behalf the funds were received, mingle the funds with the producer's own funds or with funds held by the insurance producer in any other capacity. Nothing in this article will be deemed to require an insurance producer to maintain a separate bank deposit for the funds of each insurance entity if and as long as the funds of each insurance entity are reasonably identifiable from the books of account and records of the insurance producer.
- 2. Examination of books and records [40 P.S. Sec. 323.3]** Every company or person subject to examination in accordance with this act must keep all books, records, accounts, papers, documents, and any or all computer or other recordings relating to its property, assets, business, and affairs in such manner and for such time periods as the Department, in its discretion, may require in order that its authorized representatives may readily verify the financial condition of the company or person and ascertain whether the company or person has complied with the laws of this Commonwealth.
 - a.** The Department or any of its examiners may conduct an examination under this article of any company as often as the Commissioner in his sole discretion deems appropriate but shall, at a minimum, conduct an examination of every licensed insurer at least once every five years.

- b. For purposes of completing an examination of any company, the Department may examine or investigate any person, or the business of any person, if the examination or investigation is, in the opinion of the Commissioner, necessary or material to the examination of the company.
- c. In lieu of an examination of any licensed foreign or alien insurer, the Department may accept an examination report on the company prepared by the Insurance Department for the company's state of domicile.

3. Commissions and fees [40 P.S. Secs. 310.72, 74] An insurance company and a producer may pay a commission, brokerage fee, service fee, or other compensation to a licensee for selling, soliciting, or negotiating a contract of insurance. Generally, a company or licensee may not pay a commission, brokerage fee, service fee or other compensation to an unlicensed person for activities related to the sale, solicitation, or negotiation of a contract of insurance.

- a. However, an insurance company or a producer may pay:
 - a renewal or other deferred commission to a person that is not a licensee for selling, soliciting, or negotiating a contract of insurance if the person was a licensee at the time of the sale, solicitation, or negotiation; or
 - a fee to an unlicensed person for referring someone who is interested in purchasing insurance if the referring person does not discuss specific terms of a contract of insurance and, in the case of referrals for insurance that is primarily for personal, family, or household use, the referring person receives no more than a one-time, nominal fee of a fixed dollar amount for each referral that does not depend on whether the referral results in a sale. An insurance company or producer may not pay a commission or fee to a person if the person had a license suspended or revoked.
- b. A licensed producer may charge a fee in addition to a commission to a person for the sale, solicitation, or negotiation of a contract of insurance for commercial business. The fee charged by the licensee must be disclosed in advance in writing to the person and be reasonable in relationship to the services provided.
- c. Notwithstanding other provisions of this section, no insurance producer may charge a fee for the completion of an application for a contract of insurance.

4. Prohibited acts [40 P.S. Sec. 310.11] A licensee or applicant for an insurance producer license may not:

- provide incorrect, misleading, incomplete, or false information to the Department in a license application;
- violate the insurance laws or regulations of this Commonwealth or a subpoena or order of the Commissioner or of another state's Insurance Commissioner;
- obtain or attempt to obtain a license through misrepresentation or fraud;
- improperly withhold, misappropriate, or convert money or property received in the course of doing business;
- intentionally misrepresent the terms of an actual or proposed insurance contract or application for insurance;

- admit to or be found to have committed any unfair insurance practice or fraud;
- use fraudulent, coercive, or dishonest practices or demonstrate incompetence, untrustworthiness, or financial irresponsibility in the conduct of doing business in Pennsylvania or elsewhere;
- have an insurance producer license or other financial services license, or its equivalent, denied, suspended, or revoked by a governmental entity;
- forge another person's name on an application for insurance or on any document related to an insurance or financial service transaction;
- cheat on an examination for an insurance producer license;
- knowingly accept insurance business that was sold, solicited, or negotiated by a person who is not licensed as an insurance producer;
- fail to comply with an administrative or court order imposing a child support obligation;
- fail to pay state income tax or comply with any administrative or court order directing the payment of state income tax;
- commit a felony or its equivalent;
- commit a misdemeanor that involves the misuse or theft of money or property belonging to another person;
- commit fraud, forgery, dishonest acts, or an act involving a breach of fiduciary duty;
- transfer insurance coverage to an insurer other than the insurer expressly chosen by the insured without the consent of the insured;
- fail to notify the Department of a change of address within 30 days; or
- demonstrate a lack of general fitness, competence, or reliability sufficient to satisfy the Department that the licensee is worthy of licensure.

G. UNFAIR INSURANCE PRACTICES [40 P.S. SEC. 1171.4.5]

1. Rebating [40 P.S. Secs. 310.45, 1171.5(a)(8)] No insurance producer may offer, promise, allow, give, set off, or pay a rebate of, or part of, a premium payable on the contract of insurance or on the insurance producer's commission, earnings, profits, dividends, or other benefit, or any special advantage in date of policy or age of issue, or any paid employment or contract for services of any kind, or any other valuable consideration or inducement, to or for insurance on a risk in this Commonwealth that is not specified in the contract. A person that violates this rule commits a misdemeanor of the third degree.

a. Tie-in sales prohibited [40 P.S. Sec. 310.51] No financial institution, or its director, officer, employee, or producer may require the purchase of insurance from a financial institution or from a designated insurer or producer as a condition of any loan or deposit transaction. Neither a financial institution or its director, officer, employee, or producer may reject a required policy solely because the policy was sold by a person who is not associated with the financial institution.

- b. No insured person or party or applicant for insurance may receive or accept, or agree to receive or accept, any rebate of premium or any part of a producer's commission, or share in any benefit to accrue under any policy of insurance, or any valuable consideration or inducement, other than what is specified in the policy.
- 2. Misrepresentation [40 P.S. Secs. 310.47-48, 1171.5(a)(1), (2)]** No company, officer, or producer may make, issue, circulate, or use, or cause or permit to be made, any written or oral statement misrepresenting the terms of a policy or contract of insurance. In addition, the parties may not misrepresent the terms of a contract to induce (illegal inducement) a person to lapse, forfeit, or surrender the policy issued, or to alter or convert it for any other policy or contract. An insurance producer may not make any statements that dividends are guaranteed under any insurance contract.
- 3. Twisting [40 P.S. Secs. 310.47, 473]** No insurance producer may make any misrepresentation or incomplete comparison of policies to any insured person for the purpose of inducing the policyholder to lapse, forfeit, or surrender the insurance, and take out a policy in another company, association, or exchange insuring against similar risks.
- 4. False advertising [40 P.S. Sec. 1171.5; 31 Pa. Code Ch. 51, Sec. 51]** False advertising is making, issuing, publishing, or circulating an advertisement, announcement, or statement containing any representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business that is untrue, deceptive, or misleading. It is prohibited to make, publish, issue, or circulate any estimate, illustration, circular, statement, sales presentation, or omission comparison that:
- misrepresents the benefits, advantages, conditions, or terms of any insurance policy;
 - misrepresents the premium overcharge (commonly called dividends) or share of the surplus to be received on any insurance policy;
 - makes any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy;
 - is misleading or is a misrepresentation as to the financial condition of any person, or as to the legal reserve system upon which any insurer operates;
 - uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof;
 - is a misrepresentation for the purpose of inducing or tending to induce the lapse, forfeiture, exchange, conversion, or surrender of any insurance policy;
 - is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance policy; or
 - misrepresents any insurance policy as being shares of stock.
- 5. Defamation [40 P.S. Sec. 1171.5(a)(3); 31 Pa. Code Ch. 51]** Defamation is making, issuing, publishing, or circulating any oral or written statement that is false or maliciously critical of or derogatory to the financial condition of any person, and that is meant to injure the person.

- a. Any statements that are false or maliciously critical of or derogatory to the financial condition of any insurer and that are calculated to injure an insurer are also deemed to be defamation of that insurance company.

6. Boycott, coercion, and intimidation [40 P.S. Sec. 1171.5(a)(4)]

Entering into any agreement to commit or by any concerted action committing any active boycott, coercion, or intimidation resulting in or tending to result in unreasonable restraint of or monopoly in the business of insurance is illegal.

- 7. Misappropriation of funds [40 P.S. Secs. 310.11(4), 310.42]** An insurance producer who acts in negotiating a contract of insurance for an insurance company and who embezzles or fraudulently converts to his own use, or who, with intent to use or embezzle, disposes of or fraudulently withholds any money or substitutes for money received by him as a producer, without the consent of the company, is guilty of theft.

8. Unfair discrimination [40 P.S. Secs. 477a, 1171.5; 31 Pa. Code

Ch. 145.4] Making or permitting any unfair discrimination between individuals of the same class who have the same life expectancy in the rates charged for any contract of insurance, or in any other of the terms or conditions of the contract, is prohibited. In other words, underwriting/eligibility standards based solely on race, religion, nationality or ethnic group, age, sex, family size, occupation, place of residence, or marital status are not allowed.

- a. Unfair discrimination also includes making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any insurance policy or contract or in the benefits paid, or in any of the terms or conditions of the contract.

- 9. Illegal inducement [40 P.S. Secs. 310.46, 1171.5(a)(8)]** Offering anything not expressly stated in an insurance contract, including a rebate of premiums or special favors or dividends, as an inducement to buy insurance, is illegal and a misdemeanor in the third degree.

H. PRIVACY OF CONSUMER FINANCIAL INFORMATION AND FINANCIAL INSTITUTION SALES AND DISCLOSURES [40 P.S. SEC. 310.77(A); 31 PA. CODE SECS. 146A.1-.44] This section governs the treatment of nonpublic personal financial information about individuals by various licensees (producers) of the Department, and specifically, notice requirements for life and annuity sales in Pennsylvania. In addition, this section requires a licensee to provide notice to applicants about its privacy policies and practices; describes the conditions under which a licensee may disclose nonpublic personal financial information about individuals to affiliates and nonaffiliated third parties; and provides methods for individuals to prevent a licensee from disclosing that information.

- 1. A producer (licensee) may not, directly or through an affiliate, disclose nonpublic personal financial information about a consumer to a nonaffiliated third party unless:
 - the licensee has provided to the consumer an initial notice;

- the licensee has provided to the consumer an opt-out notice (relating to the form of opt-out notice and the opt-out methods);
 - the licensee has given the consumer a reasonable opportunity, before it discloses the information to the nonaffiliated third party, to opt out of the disclosure; and
 - the consumer does not opt out.
- a. Opt out** means an instruction by the consumer to the licensee not to disclose nonpublic personal financial information about that consumer to a nonaffiliated third party.
- 2.** A licensee must provide a clear and conspicuous initial notice that accurately describes its privacy policies and practices to an individual who becomes the licensee's customer, not later than when the licensee establishes a customer relationship and a consumer, before the licensee discloses nonpublic personal financial information about the consumer to any nonaffiliated third party.
- a.** A licensee is not required to provide an initial notice to a consumer if the licensee does not disclose any nonpublic personal financial information about the consumer to any nonaffiliated third party and the licensee does not have a customer relationship with the consumer.
- b.** A licensee establishes a customer relationship at the time the licensee and the consumer enter into a continuing relationship.
- 3.** A licensee must provide a clear and conspicuous notice to customers that accurately describes its privacy policies and practices not less than annually during the continuation of the customer relationship. Annually means at least once in any period of 12 consecutive months during which that relationship exists. A licensee may define the 12-consecutive-month period, but must apply it to the customer on a consistent basis.
- 4.** The initial, annual, and revised privacy notices that a licensee provides must include:
- the categories of nonpublic personal financial information that the licensee collects;
 - the categories of nonpublic personal financial information that the licensee discloses;
 - the categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal financial information;
 - the categories of nonpublic personal financial information about the licensee's former customers that the licensee discloses and the categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal financial information about the licensee's former customers;
 - an explanation of the consumer's right to opt out of the disclosure of nonpublic personal financial information to any nonaffiliated third parties, including the methods by which the consumer may exercise that right at that time;
 - any disclosures that the licensee makes under the federal Fair Credit Reporting Act; and
 - the licensee's policies and practices with respect to protecting the confidentiality and security of nonpublic personal financial information.

5. A licensee must provide any notices that this section requires so that each consumer can reasonably be expected to receive actual notice in writing or, if the consumer agrees, electronically.
6. Licensees employed by a financial institution soliciting annuities or life insurance sales (except credit life insurance) must provide applicants with a written disclosure at or prior to the time of application.

The disclosure must include a notice stating that:

 - the insurance or annuity is not a deposit;
 - the insurance or annuity is not insured by the Federal Deposit Insurance Corporation or any other agency or instrumentality of the federal government;
 - the insurance or annuity is not guaranteed by the financial institution or an affiliated insured depository institution; and
 - the insurance or annuity is subject to investment risk, including potential loss of principal, when appropriate.
 - a. Sales of annuities or insurance, except credit insurance, by a financial institution or by a licensee employed by it must take place in a location that is distinct from the area where deposits and loan applications are discussed and accepted. Signs or other means shall be used to distinguish the insurance or annuities sales area from the deposit taking and lending areas. The Commissioner must exempt a financial institution from the requirements of this section if the number of staff or size of the facility prevents compliance.

I. INSURANCE FRAUD REGULATION [40 P.S. SECS. 325.1 to 325.62, 18

PA. C.S. SEC. 4117] A person commits an offense if, knowingly and with the intent to defraud, that person:

- presents or causes to be presented to any insurer or self-insured any statement forming a part of, or in support of, a claim that contains any false, incomplete, or misleading information concerning any fact material to the claim;
- assists, solicits, or conspires with another to prepare any statement that is intended to be presented to any insurer or self-insured in connection with a claim that contains any false, incomplete, or misleading information concerning the claim, including information that supports an amount claimed in excess of the actual loss sustained by the claimant;
- engages in unlicensed producer or unauthorized insurer activity knowingly and with the intent to defraud an insurer, a self-insured, or the public;
- knowingly benefits, directly or indirectly, from the proceeds derived from a violation of this section due to the assistance, conspiracy, or urging of any person;
- is the owner, administrator, or employee of any health care facility and knowingly allows the use of that facility by any person in furtherance of a scheme or conspiracy to violate any of the provisions of this section; or
- borrows or uses another person's financial responsibility or other insurance identification card or permits his financial responsibility or other insurance identification card to be used by another, knowingly and with intent to present a fraudulent claim to an insurer.

1. If a person is found by a court to have violated any provision of this section, he will be subject to civil penalties of not more than \$5,000 for the first violation, \$10,000 for the second violation, and \$15,000 for each subsequent violation. The penalty will be paid to the prosecuting authority to be used to defray the operating expenses of investigating and prosecuting insurance fraud. Penalties paid under this section will be deposited into the Insurance Fraud Prevention Fund created under the Insurance Fraud Prevention Act.
2. The purpose of the Insurance Fraud Prevention Act is to coordinate and fund fraud prevention activities and to support enforcement of the insurance fraud laws. The act is administered by the Insurance Fraud Prevention Authority.
 - a. Insurers authorized to write insurance in Pennsylvania must pay annual assessments to the Insurance Fraud Prevention Trust Fund. The Insurance Fraud Prevention Authority may use the money in the fund to provide financial support to:
 - law enforcement, correctional agencies, and county district attorneys' offices for programs designed to reduce insurance fraud;
 - other governmental agencies, community, consumer, and business organizations for programs designed to reduce insurance fraud;
 - programs designed to inform insurance consumers about the costs of insurance fraud and to suggest methods for preventing insurance fraud; and
 - reward programs leading to the arrest and conviction of persons and organizations engaged in insurance fraud.
 - b. There is also an insurance fraud section in the Pennsylvania attorney general's office to investigate and prosecute insurance fraud. The duties of the insurance fraud section include:
 - responding to notification or complaints of suspected insurance fraud generated by law enforcement authorities, governmental units, and the general public;
 - reviewing reports of insurance fraud submitted by authorized insurers, their employees, and licensed insurance producers and investigating incidents that require further investigation; and
 - conducting independent examinations of insurance fraud, conducting studies to determine the extent of insurance fraud, and publishing information and reports.
 - c. All applications and all claim forms should contain or attach the following notice:

“Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.”

- d. **Consent agreement** The person accused of violating this section is not prevented from entering into a written agreement not admitting or denying the charges but consenting to payment of the civil penalty. A consent agreement may not be used in a subsequent civil or criminal proceeding, but notification of any such agreement will be made to the licensing authority.
- e. All insurers, employees of insurers, and licensed producers must cooperate fully with the insurance fraud section. Anyone who has knowledge of or who believes that an insurance fraud is being committed may send a report to the section.

J. CLAIMS PRACTICES AND UNFAIR CLAIMS SETTLEMENT PRACTICES [40 P.S. SEC. 1171.5(a)(10); 31 PA. CODE CH. 146, SEC. 146] Committing any of the following acts, if done without just cause and if performed with the frequency indicating a general business practice, will be deemed to be an unfair claim settlement practice:

- Knowingly misrepresenting to claimants pertinent facts or policy provisions relating to coverages at issue
- Failing to promptly acknowledge pertinent communications with respect to claims arising under insurance policies
 - Acknowledge receipt within 10 working days of notification of a claim unless payment is made within this time
 - Respond to an inquiry from the Department within 15 working days
 - Provide the necessary claims forms within 10 working days of notification of a claim
- Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies
 - If the investigation cannot be completed within 30 days, the insurer must provide the claimant with a written explanation for the delay and state when a decision may be expected. An explanation must be provided after 30 days and every 45 days thereafter until the investigation is completed.
- Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims submitted in which liability has become reasonably clear
 - Within 15 working days after the insurer receives the proof of loss, the first-party claimant must be advised of the acceptance or denial of the claim.
 - If an insurer needs more time to determine if a first-party claim should be accepted or denied, it must provide notification of the reasons within 15 working days.
 - Upon payment of \$1,000 or more in settlement of a third-party liability claim, written notice must be mailed to the claimant at the same time payment is made.
- Compelling insureds to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them when the insureds have made claims for amounts reasonably similar to the amounts ultimately recovered
- Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration
- Attempting settlement or compromise of a claim on the basis of applications that were altered without notice to, or knowledge or consent of the insured

- Attempting to settle a claim for less than the amount to which a reasonable person would have believed one was entitled by reference to written or printed advertising material accompanying or made a part of an application
- Attempting to delay the investigation or payment of claims by requiring an insured's physician to submit a preliminary claims report and then requiring the subsequent submission of formal proof of loss forms, both of which contain substantially the same information
- Failing to affirm or deny coverage of claims within a reasonable time after a proof of loss has been completed
- Refusing payment of claim solely on the basis of the insured's request to do so without making an independent evaluation of the insured's liability based upon all available information
- Refusing to pay claims without first conducting a reasonable investigation
- Paying claims without stating under what portion of the coverage the claim is being paid

K. INDUSTRY SELF-REGULATION

1. National Association of Insurance Commissioners (NAIC) The NAIC is a voluntary organization that was formed to achieve uniformity in state insurance laws. This organization studies legislation, contacts industry representatives, and prepares model bills that commissioners may represent to their respective legislators.

- a. The NAIC has a number of task forces that consist of members from the insurance industry and the public. These task forces study a broad range of insurance regulatory issues including early detection of possible insurer insolvencies, the role of investment income and rate making, price comparisons, certification of loss reserves by qualified professionals, and so forth.
- b. The powers and duties of a Commissioner of Insurance are generally uniform in nature. As mentioned previously, they include licensing insurers, suspending or revoking licenses of insurers or licensees for just cause, examining insurers and licensees, approving rates, regulating trade practices, and any other regulatory matters involved with the business of insurance in a particular state.

L. FEDERAL VIOLENT CRIME CONTROL LAW ENFORCEMENT ACT—FRAUD AND FALSE STATEMENTS [18 USC 1033, 1034]

Specifically, this act provides that a person who has been convicted of a felony involving (1) breach of trust, (2) dishonesty, or (3) insurance crimes as defined in 18 USC Sec. 1033 is prohibited from engaging in insurance activities unless written consent is granted by the Commissioner of Insurance. Any individual who has been convicted of a felony, as described, and who desires a license to engage in insurance transactions, may seek an exemption from the federal prohibition of engaging in insurance activities by filing an application for licensure with the Commissioner of Insurance.

- 1. Section 1033 is captioned *Crimes By and Affecting Persons Engaged in the Business of Insurance Whose Activities Affect Interstate Commerce*. The section describes certain activities as crimes if they are carried out by individuals engaged in the business

of insurance and whose activities affect interstate commerce. Prohibited activities include:

- knowingly, with the intent to deceive, making any false material statement or report or willfully and materially overvaluing any land, property, or security in connection with any financial reports or documents presented to any insurance regulatory official or agency for the purpose of influencing the actions of that official or agency;
- willfully embezzling, abstracting, or misappropriating any of the monies, funds, premiums, credits, or other property of any person engaged in the business of insurance;
- knowingly making any false entry of material fact in any book, report, or statement of the person engaged in the business of insurance with the intent to deceive any person about the financial condition or solvency of such business;
- by threats of force or by any threatening letter or communication, corruptly influencing, obstructing, or impeding the proper administration of the law under which any proceeding is pending before any insurance regulatory official or agency; and
- willfully engaging in the business of insurance whose activities affect interstate commerce if the individual has been convicted of a criminal felony involving dishonesty or a breach of trust or has been convicted of an offense under Section 1033.

- a. Punishments for engaging in the prohibited activities specified range from 1 to 15 years of imprisonment plus fines established under Title 18. Under certain provisions, penalties may be more severe if the activity jeopardized the safety and soundness of an insurer and was a significant cause of an insurer being placed into conservation, rehabilitation, or liquidation.

- 2. Section 1034 is captioned *Civil Penalties and Injunctions for Violations of Section 1033*. The Section allows the US attorney general to bring civil actions against a person who engages in conduct constituting an offense under Section 1033. If found to have committed the offense, the person is subject to a civil penalty of not more than \$50,000 for each violation or the amount of compensation the person received or offered for the prohibited conduct, whichever amount is greater.

- a. If the offense contributed to the decision of a court issuing an order directing the conservation, rehabilitation, or liquidation of an insurer, the penalty is remitted to the appropriate regulatory official for the benefit of the troubled insurer's estate.
- b. Imposition of a civil penalty under Section 1034 does not preclude any other criminal or civil statutory, common law, or administrative remedy available by law to the United States or any other person.
- c. The section also permits the attorney general to seek an order (injunction) prohibiting persons from engaging in any illegal conduct.

- M. FAIR CREDIT REPORTING ACT [15 USC 1681-1681d]** The Fair Credit Reporting Act requires consumer reporting agencies to adopt reasonable procedures for exchanging information on credit, personnel, insurance, and other subjects in a manner that is fair and equitable to the consumer with respect to the confidentiality, accuracy, relevancy, and proper use of this information.
1. Reports on consumers are prohibited unless the consumer is made aware that an investigative consumer report may be made, which may contain information about the person's character, reputation, personal characteristics, and lifestyle. This notice must be given to the consumer no later than three days after a report was requested.
 2. A consumer may make a written request for a complete disclosure of the nature and scope of the investigation underlying the report. Disclosure must be made in writing within five days after the date on which the consumer's request was received.
- N. HIV TESTING [35 P.S. SECS. 7602-7605; 31 PA. CODE CH. 90C]** No HIV-related test may be performed in connection with an insurance application or transaction without first obtaining the subject's informed written consent. Any consent must be preceded, in writing, by:
- a disclosure of the effects of the test result on the approval of the application, or the risk classification of the subject;
 - information explaining AIDS, HIV, and the HIV-related test;
 - a description of the insurer's confidentiality standards;
 - a statement that, because of the serious nature of HIV-related illnesses, the subject may desire to obtain counseling before undergoing the HIV-related test; and
 - information concerning the availability of alternative HIV-related testing and counseling provided by the Insurance Department and local health departments, and the telephone number where the subject may secure additional information on such testing and counseling.
1. **Disclosure of results** The insurer is required to disclose to the subject a negative test result on an HIV-related test only if the subject requests notification. The insurer may not disclose a positive test result to the subject. On the form on which the insurer secures the subject's written consent to the HIV-related test, the subject must designate to whom a positive test result will be disclosed. The subject has the choice of designating a physician, the Insurance Department or a local health department, or a local community-based organization. The insurer must notify the designee of a positive test result. The designee will disclose a positive test result to the subject.
 2. **Permissible questions** The following AIDS questions may be (but are not required to be) used by insurers on application forms:
 - Have you ever been treated for or ever had Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?
 - Have you ever had a condition which you were medically advised is related to AIDS?
 - Have you ever had an immune deficiency disorder or disease of the lymphatic system or immune mechanism? (This may only be asked if one of the preceding questions or a similar question appears on the application.)
 - Have you ever tested positively for HIV, AIDS, or ARC?

- 3. Prohibited questions** The following AIDS questions may not be used by insurers on application forms:
- Have you received counseling for, or advice concerning, AIDS?
 - Are you homosexual?
 - Have you ever had a known indication or symptom of AIDS or ARC or other health condition?
 - Have you ever had an AIDS-related condition?
 - Have you ever had any AIDS-Related Complex?
 - Have you ever had an AIDS-related blood test?
- 4. Other permissible questions** The following questions may be (but are not required to be) used by insurers, either with or without specific AIDS questions:
- Have you ever had, experienced, been tested for, treated for, or told you had any of the following: Kaposi's Sarcoma, infections from *Pneumocystis Carinii*, Cytomegalovirus (CMV), enlargement of lymph nodes or glands, chronic diarrhea, unusual or persistent skin lesions, unexplained infections, or chronic fatigue?
 - Have you ever had major surgery that necessitated a blood transfusion?
- 5. Questions about medical consultations** An application may (but is not required to) contain a general question about a medical consultation or a visit to a physician. For example, it may ask "Have you within the past 10 years had a consultation?" or "When did you last see a physician?" If it does contain such a question, the insurer must certify in writing that information obtained on the application about a medical consultation or information visit concerning AIDS or ARC, as opposed to the actual diagnosis or treatment of AIDS or ARC, will never be used to underwrite coverage on a proposed insured.

O. ADVERTISING REQUIREMENTS [31 PA. CODE, CH. 51.1 TO .36]

- 1. Definition** An advertisement is any:
- printed and published material, audio visual material, and descriptive literature used in direct mail, newspapers, magazines, radio and television scripts, billboards, and similar displays;
 - descriptive literature and sales aids issued by a company, agent, or broker for presentation to members of the insurance-buying public, including circulars, leaflets, booklets, depictions, illustrations, and form letters; or
 - prepared sales talks, presentations, and materials for use by agents, brokers, or solicitors.
- 2. Filing requirements** No later than the first day of publication, an advertisement for mail-order solicitation of individual or franchise accident and health contracts must be filed with the Department as "Initial Filing of a Mail-Order Solicitation." Any changes in this advertisement must be filed as "Amended Filing of a Mail-Order Solicitation." A renewed filing is required two years after the first publication. An advertisement may also be submitted for voluntary review for compliance at least 30 days prior to the first publication, and the Department has the right to review all advertisements whether or not actually filed or required to be filed.

- 3. Company responsibility and control** At all times, every company must maintain complete control over the content, form, and method of distributing all advertisement about its contracts. The advertisement is the responsibility of the company, regardless of its author, creator, or designer.
- 4. Advertising file** Each company must maintain a file containing every individual contract advertisement and typical blanket, franchise, and group advertisements used by the company, and must indicate the form number of the contract advertised along with the manner of distribution. The file must be kept for four years, or until the next regular examination of the company (whichever is longer), and is subject to inspection by the Department. Any failure to maintain the file or to produce the file at the request of the Department will subject the responsible company and individuals to sanctions.
- 5. Certificate of compliance** The authorizing officer of each company must annually file a Certificate of Compliance stating to the best of his knowledge all company advertisements used during the past year complied with or were made to comply with all applicable insurance laws and regulations.
- 6. Misleading, deceptive, or unclear statements** The form and content of an advertisement must be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. An advertisement must be truthful and not be misleading in fact or implication. An advertisement is unlawful if it has the effect or tendency to mislead or deceive purchasers about benefits payable, losses covered, or premiums payable. Words and phrases that are not reasonably comprehended by the segment of the general public to which an advertisement is directed may not be used.
- 7. Inadequate disclosures** An advertisement is misleading and deceptive if it refers to a contract's benefits, costs, terms, or conditions without disclosing any of its exceptions, reductions, limitations, or restrictions that affect the basic provisions. Advertisements may not:

 - say that a medical examination is not required, without disclosing conditions relating to an insured's health that might prevent a contract from being issued or the insured from receiving full benefits;
 - falsely represent or imply that prospective insureds become group or quasi-group members and get special rates or underwriting privileges;
 - imply that a contract continues indefinitely, when it contains provisions for nonrenewal or cancellation, or allows termination for circumstances out of the insured's control;
 - state or imply that the company is licensed in Pennsylvania if it is not true (if a company not licensed in this state uses advertising likely to be seen by Pennsylvania residents, it must use the disclaimer: "This offer is not available to residents of Pennsylvania");
 - misrepresent the assets, corporate structure, financial standing, age, or the position of the company in the industry;
 - imply or create the impression that the company, its financial conditions, merits, or status are approved or endorsed by this state or the United States government;

- include a recommendation by a commercial rating system, unless the purpose and limits of the recommendation are explained;
- falsely represent that a contract is an introductory or special offer or that there are substantial advantages available only for a limited time or to a specific group of people;
- falsely represent that only a certain number of policies will be sold; or
- make unfair, incomplete, or noncomparable comparisons of policies and benefits, or make disparaging comments about competitors.

- 8. Testimonials and endorsements** Testimonials must be genuine, current, and accurate. Any financial interest in the company by the person making the statement must be prominently displayed in the advertisement. The phrase *paid endorsement* must be used if the person was compensated for making an endorsement or testimonial, and any proprietary relationship between an entity making an endorsement and the insurance company must be disclosed.
- 9. Use of statistics** An advertisement using dollar amounts of claims paid, number of persons insured, or other statistics must be accurate. No irrelevant facts may be used, and the source of any statistics must be identified.
- 10. Identification of company, policies, and contracts** An advertisement must disclose where different plans have differing benefits and premiums, or where certain benefits can only be obtained through a combination of policies. The name of the actual insuring company must be stated in the advertisement and must not resemble agencies of the federal government. All contracts must be identified by the form number, and any addresses listed must be identified as the home, branch, or district offices of the insurer.
- 11. Mail-order solicitation** A mail-order advertisement must not falsely represent that because no agent will call and no commissions are to be paid to agents the insurance is a “low cost plan,” because the cost of advertising and servicing such policies is a substantial cost in the marketing of direct-response products.
- 12. Prohibited advertising of guaranty fund [40 P.S. 991.1717]** A guaranty association has been established by law to help pay covered claims and prevent financial losses to claimants and policyholders when insurance companies who are association members become impaired or insolvent. However, it is unlawful for any insurer, agent, or other representative of the insurer to use the existence of the association for the purpose of sales, solicitation, or as an inducement to purchase any kind of insurance protected by the association.

P. DO NOT CALL LIST <https://www.donotcall.gov>

1. Pursuant to its authority under the Telephone Consumer Protection Act (TCPA), the FCC established, together with the Federal Trade Commission (FTC), a National Do Not Call Registry. The registry is nationwide in scope, applies to all telemarketers (with the exception of certain nonprofit organizations), and covers both interstate and intrastate telemarketing calls. Commercial telemarketers are not allowed to call you

if your number is on the registry, subject to certain exceptions. As a result, consumers can, if they choose, reduce the number of unwanted phone calls to their home.

2. The do-not-call registry does not prevent all unwanted calls. It does not cover the following:
 - a. Calls from organizations with which you have established a business relationship
 - b. Calls for which you have given prior written permission
 - c. Calls which are not commercial or do not include unsolicited advertisements
 - d. Calls by or on behalf of tax-exempt, nonprofit organizations
3. In addition to the establishment of a National Do Not Call Registry, there are other amendments to the Commission's rules implementing the TCPA that may reduce the number of telemarketing calls to your home.
 - a. If you subscribe to caller ID, you should know when a telemarketer is calling you. Telemarketers are required to transmit caller ID information and may not block their numbers.
 - b. Telemarketers must ensure that predictive dialers abandon no more than 3% of all calls placed and answered by a person. A call will be considered "abandoned" if it is not transferred to a live sales agent within two seconds of the recipient's greeting. As a result, you are less likely to run to answer the phone only to find silence or the "click" of the calling party disconnecting the line.
4. In addition to these changes, the rules provide the following additional guidelines.
 - a. Telephone solicitation calls to your home before 8:00 am or after 9:00 pm are prohibited.
 - b. Anyone making a telephone solicitation call to your home must provide his/her name, the name of the entity on whose behalf the call is being made, and a telephone number or address at which you may contact that entity.
 - c. Company-specific, do-not-call lists are available to consumers who wish to avoid telemarketing calls only from specific companies.

Q. PRIVACY (GRAMM LEACH BLILEY ACT)

1. Insurance and financial holding companies have the potential to capture unprecedented amounts of information about their customers. This law establishes a minimum federal standard for financial privacy. The law requires that technical, administrative, and physical safeguards be established to:
 - ensure the security and confidentiality of customer records and information;

- protect against any anticipated threats or hazards to the security or integrity of such records; and
 - protect against unauthorized access to or use of such records or information that could result in substantial harm or inconvenience to any customer.
2. Anyone about whom a company collects information is a **consumer**. A **customer** is a consumer who has an ongoing relationship with the financial institution.
 3. **Disclosure authorization** It is the responsibility of a producer to explain to an applicant the various resources from which the insurer will obtain information regarding that applicant's insurability. Applicants for insurance must be given advance written notice of an insurer's practices regarding the collection and use of personal information related to insurance transactions. Written disclosure authorization forms must be furnished stating:
 - who is authorized to disclose personal information;
 - the kind of information that may be disclosed;
 - the reason information is being collected; and how it will be used.

The applicant's signature on the disclosure form authorizes the insurer to collect and disseminate information in the manner described in the notice. The authorization is good only for a certain period. At the end of this period, another authorization must be obtained.
 4. Consumers and customers are given the opportunity to prevent the company from sharing the information it has about them. This is known as the right to **opt out**. Health information, such as that acquired during a medical exam, is subject to a stricter **opt-in** standard, meaning that companies may not share health information without receiving specific permission to do so.
 5. **Penalties** Any person who obtains information about a client without having a legitimate reason to receive it is subject to fines and imprisonment.

II. PENNSYLVANIA LAWS APPLICABLE TO LIFE INSURANCE ONLY

A. DISCLOSURE REQUIREMENTS IN THE SOLICITATION OF LIFE INSURANCE

[31 PA. CODE CH. 83] The purpose of disclosure requirements in the solicitation of life insurance is to protect the purchaser from misrepresentation, unfair comparison, and deceptive and misleading sales methods. In addition, disclosure requirements are intended to provide prospective clients with a statement containing pertinent information regarding the policy being solicited.

1. The classes of insurance that are not subject to disclosure regulations include annuities, group life insurance, credit life insurance, life insurance of \$5,000 or less, variable life insurance, life insurance issued in connection with qualified funded pension plans and qualified retirement plans, life insurance where the cost is borne in whole by the employer of the insured, life insurance issued as a result of a contractual policy change or conversion provision, and substandard solicitations to the extent the producer or company does not reasonably know the pertinent information at the time the presentation is made to a prospective insured.

- 2. Disclosure statement** Any life insurance producer or insurer soliciting life insurance business must provide any prospective purchaser with a written disclosure statement clearly labeled as such. Any disclosure statement must be a document that describes the purpose and importance of the disclosure and the significant elements of the policy and riders being offered including but not limited to:
- a statement that the disclosure is for the insured's protection, provides basic information about the cost and coverage of the insurance, and should be read carefully;
 - a statement that the disclosure statement will not be considered as an offer to contract or as altering or modifying any policy or rider that might be issued;
 - the name, age, and sex of the proposed insured, to the extent that each is known or can reasonably become known to the company or producer, or at time of presentation;
 - the source of insurance including the producer or insurer;
 - information about the basic policy, rider, or supplemental benefit built into the policy, such as a descriptive title (e.g., whole life, 20-year decreasing term, endowment at age 65) and so forth;
 - the amount of coverage and benefits offered including the face amount, retirement income, and cash surrender value;
 - premiums;
 - dividends payable;
 - surrender comparison index for policies; and
 - policy illustrations must not be made part of the contract and must clearly display the fact that values shown are not guaranteed.
- 3. Cost disclosures—life insurance comparison index disclosures [31 Pa. Code, Ch. 83.51-.57]** The purpose of cost disclosures is to provide the purchaser of life insurance a means of making a cost comparison of the same type of life insurance policies having the same premium payment period and pattern.
- a. Disclosure must be made upon delivery or earlier if requested. One common method used to compare cost involves the **Surrender Comparison Index Disclosure** and describes:
 - the name, age, and sex of the insured;
 - the face amount of the policy;
 - the descriptive title of the policy;
 - the policy number;
 - the 10-year Surrender Index and the 20-year Surrender Index per \$1,000 of face amount of coverage; and
 - an explanation of the purpose and use of the Surrender Comparison Index.
 - 1.) The Surrender Comparison Index must use the interest adjusted method using 5%.
 - b. The producer must certify that the Surrender Comparison Index Disclosure was given during the policy delivery or earlier. The insurance company must keep the certification for three years or until its next examination by the Insurance Department, whichever is later.

- 4. Penalties for violating the disclosure regulation** A producer will be fined, suffer certificate or license suspension or revocation, or both for violating disclosure regulations. An insurer will be fined, have its certificate of authority suspended or revoked, or both.

B. REPLACEMENT OF LIFE INSURANCE [31 P.S. CH. 81.1 TO 81.8] The Insurance Commissioner may make regulations governing the sale or offer of sale of life insurance when the sale or offer involves the replacement of existing life insurance policies, or the borrowing on or lapsing of existing life insurance policies. These regulations may prescribe the form in which the offer or proposal should be made; the form of notice to the insurance companies involved; the questions to be contained in the application forms for life insurance pertaining to existing insurance; and the form of notice to the purchaser.

- 1.** Under Pennsylvania law, the Commissioner may suspend or revoke the certificate or license of any insurance producer violating any replacement regulations. Replacement involves a transaction where new life insurance coverage replaces previous coverage.
- 2.** Any transaction is known as a replacement in which new life insurance protection is to be purchased and it is known, or should be known, by a producer or insurer that existing insurance is to be:
 - lapsed;
 - surrendered;
 - pledged as collateral;
 - borrowed against;
 - converted to reduced paid-up;
 - continued as extended term;
 - reissued with reduced cash value; or
 - converted so that amount or period of coverage is reduced.
- 3.** It is generally required that every authorized insurer, when replacement is involved, supply a written comparison of the policy terms, conditions, and benefits to an insured. The written comparison must be supplied within five working days following the request.
 - a.** Each insurer (except for a direct response insurer) shall provide a *Buyer's Guide* to any prospective purchaser prior to accepting the application for life insurance from the prospective purchaser.
- 4. Duties of producers with regard to replacement** Producers have several duties when soliciting life insurance or if a replacement of a life insurance policy is involved, including but not limited to the following.
 - a.** The producer must make a reasonable effort to determine if the transaction will involve the replacement of existing life insurance or an existing annuity.
 - b.** If a replacement is involved, the producer must obtain with, or as part of, each application for life insurance a statement signed by the applicant verifying that the applicant understands that a replacement is taking place.

- c. When replacement is present, a producer should secure a list of all existing policies being replaced.
- d. The producer must provide and sign a *Notice Regarding Replacement of Life Insurance and Annuities* to the applicant when replacement is involved. The producer must also obtain the applicant's signature on this form to verify that he received it.
- e. The producer must leave copies of all sales proposals or other sales material, including a copy of the *Notice Regarding Replacement*, with the applicant.

5. Duties of insurers with regard to replacement Insurance companies are required to inform all producers soliciting insurance on their behalf of the duties of a producer with regard to replacement.

- a. Insurance companies must require that its producers collect a statement signed by the applicant so that the applicant realizes a replacement is taking place.
- b. An insurer must require that its producer provide a *Notice to the Applicant* when replacement is involved.
- c. An insurer will provide *Comparative Information Forms* when necessary. The replacing insurer must write to the existing insurer about the proposed replacement and provide comparable data or a ledger. Within 20 days of that written communication, the existing insurer must provide a copy of the policy ledger to the policyowner (and to the replacing insurer as well if requested).
- d. Insurers must maintain files of client records for three years after they have ended the relationship or until the next examination by the Insurance Department, whichever is later.
- e. Insurers must maintain files of all information concerning a policy replacement. The replacing insurer and the conserving insurer must keep records of their dealings for three years after the transaction or until the next examination by the Insurance Department, whichever is sooner.
- f. Upon delivery of the replacing policy, the owner must be given (in writing) an unconditional right to a full refund (free look) within 20 days of delivery.

C. SALES PRACTICES No life insurance company, producer, solicitor, or other representative may make any statement or reference relating to the growth of the life insurance industry or to the tax status of life insurance companies in connection with any solicitation of an application for life insurance in a context that could reasonably be understood to interest a prospect in the purchase of shares of stock in an insurance company rather than in the purchase of a life insurance policy.

- 1. No life insurance company, producer, solicitor, or other representative may make any statement that reasonably gives rise to the inference that a prospective insured, by

virtue of purchasing a policy of life insurance, will enjoy a status common to a stockholder or will acquire a stock ownership interest in the insurance company.

2. No life insurance company, producer, solicitor, or other representative may make any statement implying that a life insurance policy was sold by the investment department of the company.
3. No life insurance company, producer, solicitor, or representative may make any statement or reference implying that by purchasing a life insurance policy, the purchaser will receive special treatment from the insurance company, including the payment of dividends (unless the benefits are specifically provided in the insurance contract).

D. SEPARATE ACCOUNTS [40 P.S. SEC. 506.2; 31 PA. CODE, CH. 82.1, .14, .81; 82.41-.51] Insurers organized under Pennsylvania law may establish one or more separate accounts. These are usually used in connection with the operation of variable annuities and variable life contracts.

1. Included within these separate accounts may be the proceeds used for life insurance and annuities payable in fixed or variable amounts. In addition, reserves that guarantee dollar amounts and the duration of funds guaranteed as to the principal amount or a stated rate of interest may not be included in these accounts.
2. An insurance company issuing variable life insurance contracts must adopt standards of suitability regarding any recommendations that an applicant purchase a variable life insurance policy based upon information provided by the applicant. Standards of suitability also apply to producers.
3. Applicants will be provided a statement of the investment policy of the separate account, the approximate percentage of an annual gross premium for each year and for the life of the policy, and all commissions paid to all producers.
4. Before a producer may solicit or offer any variable life policy, he must file evidence with the Commissioner of any license or authorization required by any federal or state securities law.
5. Separate accounts will maintain assets with fair market value at least equal to the greater of the valuation reserves for the variable portion of the variable life insurance policies or the benefit base for the policies.

E. MISCELLANEOUS PROVISIONS AND REGULATIONS AND INFORMATION

1. **Protection of beneficiaries from creditors** If a life insurance policy is effected by any person on his own life or on another life, the lawful beneficiary is entitled to its proceeds. The creditors of the deceased may not attach any lien or claim to the policy proceeds.
 - a. **Beneficiary's creditors** If proceeds are left with an insurer, the proceeds will be protected against any claims by the beneficiary's creditors.

delivery receipt must be used. This receipt must be in at least a duplicate set and state the date the policy or annuity was received by the policyholder. The receipt date is the date on which the policyholder and producer sign the delivery receipt, and this date commences any applicable policy or annuity examination period (free-look period). Copies of the delivery receipt must be provided to the policyholder on the date of policy or annuity delivery and to the issuing insurer.

- a. When the individual policy or annuity is delivered to the policyholder by a means other than by hand delivery by the producer, the insurer must establish appropriate means of verifying delivery by the producer of the policy or annuity and of establishing the date from which any applicable policy or examination period will commence. A certificate of mailing is adequate proof of delivery.

8. Insurable interest [40 P.S. Sec. 512]

- a. Every person may insure his own life, but a person may not insure the life of someone else unless the beneficiary under the policy has an insurable interest in the life of the insured. If a life insurance policy meets this requirement, a later transfer of the policy is valid even if the transferee then has no insurable interest in the life of the insured. In other words, for life insurance, insurable interest need only exist at the time of application.
- b. For people related by blood or law, **insurable interest** means an interest engendered by love and affection. In other cases, insurable interest means a lawful economic interest in having the life of the insured continue, as distinguished from an interest that would arise only by the insured's death.
- c. The general rule is that a life insurance policy may not be delivered in Pennsylvania unless there is an application by the person to be insured. However, a person liable for the support of a child may take out a policy on the child. In addition, a business entity that provides benefits to its officers, directors, or employees may insure those personnel without their signing a personal application if the entity notifies the personnel in writing of the intent to purchase the insurance and obtains their prior written consent.
- d. A charitable organization that meets the requirements of Section 501(c)(3) of the Internal Revenue Code may own or buy life insurance on an insured who consents to the ownership or purchase of the insurance.

9. Free look [40 P.S. Sec. 510c(a), (2), (3), (b1)] Individual life insurance policies delivered in Pennsylvania must allow the policyholder to return the policy within 10 days of its delivery for a full refund if the policyholder is not satisfied with it for any reason. The free look period is 45 days for individual variable policies that are issued as replacements by the same insurer that issued the original policy. Variable life replacement policies issued by a different insurer must allow a 20-day return period.

10. Grace period [40 P.S. Sec. 510(b)] Every life insurance policy issued for sale in Pennsylvania must provide the insured with a grace period of 30 days or one month within which any premium after the first year may be paid. The insurer may charge

interest on the unpaid premium at the rate of no more than 8% per year for the number of days in which the overdue premium is not paid. The policy continues in full force during the grace period. If the policyholder makes a claim on the policy during the grace period, the insurer may deduct the amount of the premium due and any interest charges on the unpaid premium from any settlement paid under the policy.

11. Conversion to individual policy [40 P.S. Sec. 532.7] When an individual insured under a group life insurance policy becomes entitled to have an individual life policy issued without evidence of insurability (subject to application and payment of the first premium within the period specified in such policy) but is not given notice at least 15 days before the expiration date of the eligibility period, the individual must be allowed an additional period to exercise the conversion right. The additional period expires 15 days after the individual is given the notice, but may not extend beyond 60 days after the expiration date of the period provided in the policy.

12. Accelerated (living) benefit provisions [31 Pa. Code, Ch. 90f.3, .4]

- a. Accelerated (living) benefit provisions in individual life insurance policies are acceptable in Pennsylvania if they provide that a living benefit will be paid in any of the following situations:
 - The insured's life expectancy is expected to be for a limited period of time ranging from six months or less, to 12 months or less.
 - The insured suffers a total and permanent disability.
 - The insured is confined to an eligible health care facility with the expectation that the insured will remain in the facility for her entire lifetime.
- b. An accelerated death benefit must be at least 25%, but no more than 100%, of the total death benefit affected by the benefit payment and may be paid periodically or in a lump sum.
- c. The policy must contain a clear statement that the death benefit and any accumulation values and cash values will be reduced if an accelerated death benefit is paid.
- d. Accelerated benefit provisions may contain certain exclusions, such as eliminating benefits for conditions that result from suicide or attempted suicide, chronic alcoholism, engaging in an illegal occupation, and acts of war.

13. Policy illustrations [40 P.S. Secs. 625-7 to 625-8]

- a. A producer may only use and may not withhold, alter, change, or in any way modify the results of a life insurance or annuity illustration system provided by an insurer or approved in writing by an officer of the insurer. Life insurance and annuity illustrations may not be made part of any life insurance or annuity policy issued.
- b. Each insurer must notify the Commissioner whether a life insurance policy form is to be marketed with or without an illustration. If a life insurance policy form is

identified by the insurer as one to be marketed with an illustration, a basic illustration containing information prescribed by law is required. If a computer screen is used at the time of sale, additional procedures apply to ensure the applicant will receive a hard copy of the illustration in a timely basis.

- c.** When using an illustration in the sale of a life insurance policy, an insurer or its producers may not:
- represent the policy as anything other than a life insurance policy;
 - use or describe nonguaranteed elements in a manner that is untrue, deceptive or misleading, or has the capacity or tendency to mislead;
 - state or imply that the payment or amount of nonguaranteed elements is guaranteed;
 - use an illustration that does not comply with the requirements of state law;
 - use an illustration that at any policy duration depicts policy performance more favorable to the policyowner than that produced by the illustrated scale of the insurer whose policy is being illustrated;
 - provide an applicant with an incomplete illustration;
 - represent in any way that premium payments will not be required for each year of the policy in order to maintain the illustrated death benefits, unless such representation is true;
 - use the term *vanish* or *vanishing premium* or any similar term that implies the policy may become “paid up” to describe a plan whereby nonguaranteed elements are used to pay all or a portion of future premiums;
 - except for policies that can never develop nonforfeiture values, use a lapse-supported illustration; or
 - use an illustration that is not self-supporting.
- d.** If an interest rate used to determine the illustrated nonguaranteed elements is shown, it may not be greater than the earned interest rate underlying the disciplined current scale.
- e.** These requirements do not apply to variable life insurance, credit life insurance, life insurance issued in connection with a pension, profit sharing or other benefit plan qualifying for deductibility of premiums, or life insurance policies for which there are no illustrated death benefits exceeding \$10,000 on any individual.
- f.** A proper illustration must have the date of preparation and pagination. It must also include the:
- name of the insurer;
 - name and address of the producer, if applicable;
 - generic product name and form number;
 - name, age, and gender of insured;
 - underwriting class of the insured;
 - initial death benefit; and
 - dividend option used, if applicable.

- 14. Reinstatement [40 P.S. Sec. 510(k)]** A life insurance policy written in the Commonwealth must have a minimum of three years to reinstate such policy. The three-year time period starts from the last premium paid.
- 15. Retained asset account** A retained asset account is a life settlement option available to beneficiaries at the death of the insured. The beneficiary has the option to have the death benefit placed in this account with the life insurer. The beneficiary will receive interest on the account and have access to the money via check-writing privileges.
- 16. Return of premium (ROP) term life insurance** Return of premium term policies will return all or a part of the premium paid for the policy if the insured is still alive at the end of the policy term. The premium for the ROP term policy will be higher than a comparable level term policy.

F. VIATICAL SETTLEMENTS [40 P.S. SECS. 626.1 TO 626.8]

1. Definitions

- a. Viatical settlement contract** A **viatical settlement contract** is a written agreement between a viatical settlement provider and a person owning a life insurance policy in which the policyowner is paid an amount less than the policy's death benefit in exchange for the viator's (owner's) assignment, transfer, or sale of the death benefit or ownership of any portion of the policy.
- b. Viatical settlement provider** A **viatical settlement provider** is a person, other than a viator, who enters into or effectuates a viatical settlement contract.
- c. Viatical settlement broker** A **viatical settlement broker** is a person who, on behalf of an owner-viator and for a fee, commission, or other consideration, negotiates viatical settlements between a viator and one or more viatical settlement providers.
- d. Viatical settlement purchaser** A **viatical settlement purchaser** is a person who purchases a life insurance policy that is the subject of a viatical settlement contract.
- e. Viator** The **viator** is the (original) owner of a life insurance policy who enters into a viatical settlement contract.
- f. Chronically ill** To be **chronically ill** is to be unable to perform at least two activities of daily living (eating, toileting, transferring, bathing, dressing, or continence) or requiring substantial supervision to protect oneself from threats to health and safety due to severe cognitive impairment.
- g. Terminally ill** To be **terminally ill** is to have an illness that can reasonably be expected to result in death in 24 months or less.

2. Fraudulent viatical settlement acts All of the following are considered fraudulent viatical settlement acts:

- Presenting or preparing false material information or concealing material information in connection with an application for a viatical settlement contract, an insurance policy, or a claim for benefits
- Destroying, concealing, or altering the assets or records of a licensee or other person engaged in the business of viatical settlements
- Misrepresenting or concealing the financial condition of a licensee or insurer
- Engaging in the business of viatical settlements without a license, certificate of authority, or other legal authority
- Filing a document that contains false information or otherwise conceals information about a material fact with the Commissioner or an insurance regulator in another jurisdiction
- Presenting or preparing an insurance policy with knowledge that it was fraudulently obtained in a viatical settlement transaction
- Embezzlement, theft, or conversion of money or other property in connection with a viatical settlement
- Attempting to commit or helping someone else commit any of these acts

3. Licensing

- a. Viatical settlement brokers and providers must be licensed by the Department of Insurance. To qualify for a license, the applicant must:
 - submit an application and pay the required fees;
 - be competent and trustworthy and intend to act in good faith under the license;
 - have a good business reputation and be qualified for the license through experience, training, or education;
 - if a legal entity, provide a certificate of good standing from its state of domicile;
 - certify that it has implemented an anti-fraud plan that meets the requirements of state law; and
 - for out-of-state companies, provide the name of a designated agent.
- b. An applicant for a viatical settlement provider license must also:
 - provide a detailed plan of operation;
 - submit certain required financial statements; and
 - be bonded or otherwise provide for its financial accountability as required by the Department.
- c. The license application will be approved or disapproved within 90 days of receipt unless the applicant waives the time period.
- d. Viatical settlement licenses expire and may be renewed on the anniversary month of the initial date of licensure. Failure to pay the required renewal fee or submit the renewal form as required by the Department will be considered a voluntary termination of the license.

4. Required disclosures

- a.** A provider or broker must disclose certain information to the viator (policyowner) no later than the time the application for the contract is signed by all parties. The following disclosures must be provided in a separate document signed by the viator and the provider or broker.

 - Possible alternatives to viatical settlement contracts should be considered, including accelerated death benefits or policy loans offered under the viator's life insurance policy.
 - Some or all of the proceeds of the viatical settlement may be taxable under federal income tax and state franchise and income taxes.
 - Proceeds of the viatical settlement could be subject to the claims of creditors.
 - Receipt of the proceeds of a viatical settlement may adversely affect the viator's eligibility for Medicaid or other government benefit.
 - The viator has the right to rescind a viatical settlement contract for 15 calendar days from the date of receipt of the viatical settlement proceeds.
 - Funds will be sent to the viator within three business days after the viatical settlement provider receives the insurer or group administrator's acknowledgment that ownership of the policy has been transferred and the beneficiary has been designated.
 - Entering into a viatical settlement contract may cause other policy rights or benefits, including conversion rights and waiver of premium benefits, to be forfeited.
 - All medical, financial, or personal information obtained by a viatical settlement provider or viatical settlement broker about an insured may be disclosed as necessary to effect the viatical settlement.
 - All information provided by a viator or insured to a viatical settlement provider or broker will be shared with the insurer that issued the life insurance policy that is the subject of the transaction.
- b.** Before the application for a viatical settlement contract is signed by all parties, the provider or broker must provide the viator with a brochure describing the process of viatical settlements.
- c.** A viatical settlement provider must also disclose certain information to the viator no later than the time the viatical settlement contract is signed by all parties. The following disclosures must be conspicuously displayed in the contract or in a separate document signed by the viator and the provider or broker:

 - Any affiliation between the viatical settlement provider and the issuer of the policy to be viaticated
 - Name, address, and telephone number of the viatical settlement provider
 - If a policy to be viaticated has been issued as a joint policy or involves family riders or any coverage of a life other than the insured, that coverage on other lives under the policy may be lost, and the viator should consult with the insurance producer or insurer issuing the policy for advice on the proposed viatical settlement

- Dollar amount of the current death benefit payable to the viatical settlement provider under the policy
 - If known, the availability of any additional guaranteed insurance benefits, the dollar amount of any accidental death and dismemberment benefits under the policy, and the viatical settlement provider's interest in those benefits
 - Name, business address, and telephone number of the independent third party escrow agent, and the fact that the viator or owner may inspect or receive copies of the relevant escrow or trust agreements or documents
- d.** Before the contract is signed by all parties, a viatical settlement broker must disclose how his potential compensation is calculated. This information must be conspicuously displayed in a document signed by the viator and the broker.
- e.** If the viatical settlement provider transfers ownership or changes the beneficiary of the policy, the provider must notify the insured of the change within 20 days.

5. General rules

- a.** Before the viatical settlement contract is executed, a viatical settlement provider must obtain a witnessed document in which the viator:
- consents to the viatical settlement contract;
 - represents that he has a full and complete understanding of the contract and the benefits of the insurance policy;
 - acknowledges that he has entered into the contract freely and voluntarily;
 - if applicable, acknowledges that he is terminally or chronically ill and that the illness was diagnosed after the policy was issued; and
 - acknowledges that he is of sound mind and under no constraint or undue influence.
- b.** The viatical settlement broker also must obtain a document in which the insured consents to the release of his medical records, and if the life insurance policy is being viaticated within two years from its date of issuance, consents to the tolling of the policy's contestable period until after the insurer has completed its investigation regarding the validity of the policy.
- c.** Within 20 days after a viator executes documents necessary to transfer any rights under an insurance policy, or within 20 days of entering any agreement to viaticate the policy, the viatical settlement provider must give written notice to the insurer that issued the policy that the policy has or will become a viaticated policy. If the viator is terminally or chronically ill, the notice must be accompanied by a written acknowledgement of this fact from the viator. The provider or broker must also send the insurer a copy of the medical release, a copy of the viator's application for the viatical settlement, and a request for verification of coverage. The insurer must verify coverage within 30 days of the date the request is received.

- d. The viator has an unconditional right to rescind the contract for 30 days from the date of the contract and for at least 15 days after receiving the viatical settlement proceeds. The proceeds of the viatical settlement must be placed in an escrow or trust account within three days after receipt of the documents required to viaticate the policy. After these funds are deposited, they must be paid to the viator within three days.
- e. After the viatical settlement occurs, the provider or broker must limit the number of times the insured is contacted to determine the insured's health status. The insured may be contacted once every three months if he has a life expectancy of more than one year and once per month if he has a life expectancy of one year or less.
- f. A viatical settlement broker may not receive a fee, commission, or other valuable consideration from a viatical settlement provider unless the provider is licensed in Pennsylvania. Regardless of how he is compensated, a broker represents only the viator and owes a fiduciary duty to act according to the viator's instructions and in the viator's best interests.
- g. Except as otherwise provided by law, the parties involved in a viatical settlement transaction with actual knowledge of an insured's identity, health information, or financial information may not disclose that information to any other person.

G. VARIABLE ANNUITIES [31 PA. CODE CH 85.1-.4, .21-.27]

1. Definitions

- a. **Variable accumulation annuity contract** This is an annuity policy or contract, other than a variable annuity, under which amounts accumulated for the purchase of a fixed annuity or a fixed annuity and a variable annuity, where the accumulation values vary according to the investment experience of a separate account. The fixed annuity shall be purchased at rates at least as favorable to the policyholder as those stated in the variable accumulation annuity contract.
 - b. **Variable annuity contract** This is any policy or contract that provides for deferred or immediate annuity payments, the amount of which, after such payments have commenced, varies according to the investment experience of a separate account maintained by the insurer for the purpose of funding this contract.
2. The Commissioner is authorized to conduct reviews in issuing a variable annuity or variable accumulation annuity contract with guaranteed benefits.
 3. All contracts issued must comply with federal and state securities laws. Any person who sells any type of variable annuity must also be register with FINRA and comply with all rules and regulations when selling, maintaining, or servicing such a contract.

4. Separate accounts

- a. The investments and operation of any separate account established in connection with any variable annuity contract or a variable accumulation annuity contract shall be examined periodically by the Department.
- b. Any income, gains, or losses realized or unrealized on each separate account shall be credited to or charged against the amount allocated to such separate account without regard to the other income, gains, or losses of the company. However, a variable accumulation or variable annuity contract on a group basis may provide for the interdependence of two or more separate accounts established in conjunction with such contract.
- c. Concerning any sales, exchanges, or transfers between accounts, each will be made by a transfer of cash, or with the approval of the Department, by a transfer of securities having a valuation that may be readily determined in the marketplace. The Department may also authorize other transfers among such accounts if, in its opinion, such transfers would be in the best interests of the contract holders, the company, and the public.
- d. Each life insurance company shall, at the time of its annual statement, submit a separate annual statement for the business of its separate accounts. This statement shall be in the form prescribed by the Department and shall include details to all of the income, disbursements, assets, and liability items associated with any separate account. The Department may, in addition, require of a company from time to time, such other statements concerning the business of its separate accounts as the Department may deem necessary.
- e. **Statements to policyholders** Any company issuing individual variable annuity contracts or individual variable accumulation annuity contracts shall mail to the contract holder, at least once in each contract year, an annual statement of values. The statement must include the number of accumulation units and the value of the account. This statement shall be mailed out on a fixed date annually (usually the anniversary date of the annuity).

H. SUITABILITY OF ANNUITIES [40 P.S. SEC 627-1 TO -7; ACT 14 OF 2010]

- 1. This article shall apply to any recommendation to purchase or exchange an annuity made to a consumer by an insurance producer, or an insurer where no producer is involved, that results in the purchase or exchange recommended.
- 2. **Duties of insurers and insurance producers; procedures**
 - a. **General duties** In making a recommendation to a consumer for the purchase of an annuity or the exchange of an annuity that results in another insurance transaction or series of insurance transactions, the insurance producer, or the insurer where no insurance producer is involved, shall have reasonable grounds for believing that the recommendation is suitable for the consumer on the basis of the facts disclosed by the consumer as to the consumer's investments and other insurance products and as to the consumer's financial situation and needs.

b. Consumer information Prior to the execution of a purchase or exchange of an annuity resulting from a recommendation, an insurance producer, or an insurer where no insurance producer is involved, shall make reasonable efforts to obtain information concerning all of the following:

- 1.) The consumer's financial status
- 2.) The consumer's tax status
- 3.) The consumer's investment objectives
- 4.) Other information used or considered to be reasonable by the insurance producer, or the insurer where no insurance producer is involved, in making recommendations to the consumer

c. Neither an insurance producer nor an insurer where no insurance producer is involved shall have any obligation to a consumer to recommend an annuity when the consumer:

- 1.) refuses to provide relevant information requested by the insurer or insurance producer;
- 2.) decides to enter into an insurance transaction that is not based on a recommendation of the insurer or insurance producer; and
- 3.) fails to provide complete or accurate information.

d. Supervision of recommendations

- 1.) An insurer shall assure that a system to supervise recommendations, of its producers, that is reasonably designed to achieve compliance with this article, or shall establish and maintain such a system that includes at least the following:
 - a.) Maintaining written procedures
 - b.) Conducting periodic reviews of its records that are reasonably designed to assist in detecting and preventing violations of this article

3. Compliance with other rules Sales made by an insurance producer subject to and in compliance with the Financial Industry Regulatory Authority Conduct Rules pertaining to suitability satisfies the requirements under this section for the recommendation of annuities. Nothing in this subsection shall limit the Commissioner's ability to enforce the provisions of this article. (Pennsylvania did not enact a specific annuity one-time initial training course requirement.)

4. Internal audit and compliance procedures Nothing in this article exempts an insurer from the internal audit and compliance procedure requirements.

5. **Corrective action** The Commissioner may order an insurer, insurance producer, general agent, or independent agency to take reasonably appropriate corrective action for any consumer harmed by the insurer's or by its insurance producer's violation of this article. Any penalties due may be reduced or eliminated by corrective actions taken.
6. **Recordkeeping requirements** An insurer, general agent, independent agency, and insurance producer shall maintain or be able to make available to the Commissioner records of the information collected from the consumer and other information used in making the recommendations that were the basis for insurance transactions for five years after the insurance transaction is completed by the insurer. An insurer is permitted, but shall not be required, to maintain documentation on behalf of an insurance producer.
7. **Penalties** Upon a determination by hearing that this article has been violated, the Commissioner may pursue one or more of the following courses of action:
 - a. Issue an order requiring the person in violation to cease and desist from engaging in the violation
 - b. Suspend or revoke or refuse to issue or renew the certificate or license of the person in violation
 - c. Impose a civil penalty of not more than \$5,000 for each violation
 - d. Impose any other penalty or remedy deemed appropriate by the Commissioner, including restitution.
8. Following the passage of SB237 in 2009 and HB1251 in 2010, as of publication date, Pennsylvania does not require special annuity training upon licensure.

III. PENNSYLVANIA LAWS APPLICABLE TO ACCIDENT AND HEALTH INSURANCE ONLY

- A. **CONSIDERATIONS IN REPLACING HEALTH INSURANCE [31 PA. CODE CH. 88.101-.103]** When accident and health insurance contracts are to be replaced in this state, several policy provisions must be scrutinized to ensure that a producer is not engaged in any misrepresentation.
 1. **Primary provisions to be scrutinized** Several relevant provisions should be scrutinized including preexisting conditions, waiting periods, exclusions, limitations, insurer underwriting requirements, and so forth.
 2. The application for health insurance must contain a question to elicit information as to whether the coverage applied for is to replace a policy that is currently in force. If a replacement is involved, the producer must provide, at the time of application, a *Notice to Applicant Regarding Replacement of Accident and Sickness Insurance*.

3. If a producer engages in misrepresentation during the replacement of health insurance contracts in this state, he may be exposed to errors and omissions liability.

B. APPLICATION RESPONSIBILITIES OF PRODUCERS No one other than the applicant may alter any written application for insurance, by erasure, insertion, or otherwise, without the applicant's written consent. Making any alteration without the consent of the applicant is illegal. Advertising the security provided by the State Guaranty Fund is prohibited.

C. MINIMUM STANDARDS OF ACCIDENT AND HEALTH INSURANCE

[40 P.S. SECS. 776.1-.7] The purpose of these standards is to provide for reasonable standardization of terms and coverages contained in individual accident and health insurance policies, nongrouped subscriber contracts issued by health plan corporations, or non-profit health service plans. Statutes regarding minimum standards will not apply to credit accident and health insurance. Categories of plans include:

- basic hospital expense coverage;
- basic medical-surgical expense coverage;
- hospital confinement indemnity coverage;
- major medical expense coverage;
- disability income protection coverage;
- accident only coverage;
- specified disease or specified accident coverage; and
- supplemental coverage.

1. **Terms of renewability** Each policy of accident and health insurance covered by Pennsylvania law must include a renewal, continuation, or nonrenewal provision. The language or specifications of this provision must be consistent with the type of contract to be issued such as noncancelable and guaranteed renewable, guaranteed renewable, renewable at the option of the insurer, and so forth.
2. **Outlines of coverage** In order to provide for full and fair disclosure in the sale of all accident and health policies, these policies must be delivered in this state along with an outline of coverage. An outline of coverage briefly describes the terms and benefits provided by the contract. These outlines generally must meet requirements set forth by the Commissioner.
3. **Conditions of eligibility** Under accident and health insurance contracts issued in this state, eligible family members may include the insured, his spouse, children, and his spouse's children who are younger than age 19 (see details below), unless a dependency test is specified, and any other person dependent upon the insured.
4. **Preexisting conditions** A policy of accident and health insurance must clearly disclose the intent of the insurer as to the applicability or nonapplicability of coverage relating to preexisting conditions. If coverage of the policy is not to be applicable to preexisting conditions, the policy must specify (prominently on its face page) that coverage pertains solely to accidental bodily injuries resulting from accidents occurring after the effective date of coverage, and that sickness is limited to that which is

diagnosed or treated subsequent to the effective date of coverage or expiration of the probationary period, if any. Preexisting condition definitions and rules vary between individual and group plans.

- a. Under the federal Health Insurance Portability and Accountability Act (HIPAA), certain limits were imposed on preexisting conditions—the exclusion limit is one year for group disability income policies and individual medical policies issued on a simplified issue (nonmedical) basis. Then, as of January 1, 2014, exclusions in medical insurances due to preexisting conditions became illegal under the Patient Protection and Affordable Care Act of 2010 (PPACA).

5. Probationary period Probationary periods in accident and health contracts delivered or issued for delivery in this state shall not exceed 30 days (with some exceptions including elective surgery).

6. Exceptions, exclusions, limitations, and reductions [31 Pa. Code Ch. 88.84] All exceptions, exclusions, limitations, and reductions must be clearly expressed as a part of the benefit provision to which it applies, or if applicable to more than one benefit provision, shall be set forth as a separate provision and appropriately (prominently) captioned. All exclusions must be specifically listed in any accident and health contract delivered or issued for delivery in this state.

- a. General exclusions shall conform with the following:
 - 1.) Loss sustained or expenses incurred while on active duty as a member of the armed forces of any nation, or losses sustained or expenses incurred as a result of act of war whether declared or undeclared
 - 2.) Suicide or intentionally self-inflicted injuries
 - 3.) Sickness or injury covered by any Workmen's Compensation Act or Occupational Disease Law or by United States Longshoreman's Harbor Workers' Compensation Act (33 U.S.C.A. §§ 901 — 950)
 - 4.) Mental, nervous, or emotional disorders
 - 5.) Aviation hazards except while flying as a fare-paying passenger on a commercial airline
 - 6.) Participation in a riot or insurrection
 - 7.) Cosmetic surgery except when necessitated by covered sickness or injury
 - 8.) Named hazardous occupations
 - 9.) Named hazardous sports or hobbies
 - 10.) Normal pregnancy, childbirth, and miscarriage

11.) Exclusions which, in the opinion of the Commissioner, are justified by special circumstances or the particular coverage of the policy

12.) Preexisting conditions (where allowed)

13.) Commission of or attempt to commit a felony

b. Additional specific exclusions are outlined and allowed for certain medical and hospital policies.

7. Free look [40 P.S. 752(A)(10); 31 Pa. Code Ch. 89.73] Except for a single premium nonrenewable policy, each individual accident and health insurance policy issued in Pennsylvania must include a notice stating that the policyholder has 10 days after the date of policy delivery in which to return the policy and receive a full refund of premiums if not satisfied for any reason.

D. POLICY CLAUSES, PROVISIONS, AND STATE-MANDATED COVERAGES

1. Coverage of mentally or physically handicapped [40 P.S. Sec. 752(A)

(9)] As you will read, children are normally covered by a parent's health plan until age 19. The coverage of any unmarried family member insured by an accident and health policy who is, before age 19, mentally or physically incapable of earning his own living on the date as of which the dependent status of a covered family member would otherwise expire because of age will continue under the policy while the policy remains in force or is replaced by another policy as long as the incapacity continues and as long as the dependent remains chiefly financially dependent on the policyholder (parents) provided that due proof of the incapacity is received by the insurer within 31 days of the expiration date.

2. Coverage of newborns [40 P.S. Secs. 771-775.2; 31 Pa. Code, Ch.

89.201-.209] All individual and group health insurance policies issued in this state that provide coverage for a family member of the insured or subscriber must cover a newly born child of the insured or subscriber from the moment of birth.

a. Coverage for newly born children, including prematurity, shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

b. If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of the birth of the newly born child and payment of the required premium or fee must be furnished to the insurer within 31 days after the date of the birth in order to have the coverage continued beyond the 31-day period.

c. Adopted children coverage [40 P.S. Sec. 775.1] An adopted child must be treated the same as any other dependent under a health insurance contract.

- d. Childhood immunizations [40 P.S. Sec. 3503; 31 Pa. Code, Sec. 89.806]** A health insurance policy that provides coverage for a child covers the cost of immunizations up to 150% of the average wholesale price of the immunizing producer.
- 3. Postpartum coverage [40 P.S. Sec. 1583]** Every health insurance policy that provides maternity benefits must provide coverage for a minimum of 48 hours of inpatient care following normal vaginal delivery and 96 hours of inpatient care following Caesarean delivery or complications. A health insurance policy may also provide for a shorter length of stay, but only if the treating or attending physician determines that the mother and newborn meet medical criteria for safe discharge. The health insurance policy must provide coverage for at least one home health care visit within 48 hours after discharge when discharge occurs prior to the times set forth above.
- 4. Coverage for annual gynecological examinations and routine Pap smears [40 P.S. Sec. 157(1), (2)]** Any individual or group health insurance policy must provide coverage for annual gynecological exams, including a pelvic examination and clinical breast exam, and routine Pap smears.
- 5. Serious mental illness [40 P.S. Sec. 764g]** Serious mental illness means any of the following mental illnesses as defined by the American Psychiatric Association in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*: schizophrenia, bipolar disorder, obsessive compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo affective disorder, and delusional disorder.
- a.** Group health insurance policies issued to groups of 50 or more employees must provide coverage for serious mental illnesses that meets the following minimum requirements.
- Coverage for serious mental illnesses must include at least 30 inpatient and 60 outpatient days annually.
 - Insureds must be able to convert coverage of inpatient days to outpatient days on a one-for-two basis.
 - There must be no difference in either the annual or dollar limits in coverage for serious mental illnesses and any other illnesses.
 - Cost-sharing arrangements, such as deductibles and co-payments, for coverage of serious mental illnesses may not prohibit access to care.
- 6. Additional mandated benefits** Any individual or group health policy issued in Pennsylvania must provide coverage for dependent children; cover treatment for alcohol abuse and dependency; provide coverage for cancer therapy including chemotherapy and cancer hormone treatments; and mammography coverage (each year) for women over age 40 and those under age 40 as recommended by a physician. In addition, state-approved uniform claims forms must be utilized.
- 7. Preexisting conditions [31 Pa. Code, Sec. 89.402-.406]** In Pennsylvania, preexisting conditions for group insurance may not be defined more restrictively than a disease or physical condition caused by illness or injury for which medical advice or

treatment has been received within 90 days immediately prior to becoming covered under the group contract. Such a condition must generally be covered after the person has been covered for more than 12 months under the group contract. Note that the PPACA of 2010 now outlaws any preexisting condition exclusions in medical insurance. Exclusions may still apply for other types of plans.

- a. Long-term disability benefit provisions may require that the total disability resulting from a preexisting condition commence after the individual has been covered for more than 12 months under the group contract.
- b. Unless disallowed by the Affordable Care Act, at the time of enrollment, group members must receive a written disclosure statement informing them that if the group member or any covered dependents have received medical care or advice in the past 90 days for a disease or physical condition, that condition will not be covered until the group contract has been in effect for at least one year for the covered person.
- c. When a group contract replaces another group contract, only preexisting conditions already excluded in the original policy may be excluded by the new policy.
- d. Blanket or group student accident and sickness insurance and group mortgage disability insurance may not include preexisting condition exclusions.

8. Conversion privilege [40 Pa. Code, Secs. 756.2, 981-9] Group policies that provide hospital, surgical, or medical expense benefits on an expense-incurred basis must include an option for conversion of coverage when insurance under the group policy has been terminated for any insured who has been continuously insured by the group policy for three months or more. This does not apply to indemnity, specific disease, or accidental injury-only policies.

- a. A member may convert to an individual policy without evidence of insurability after applying in writing and paying the first premium within 31 days after the group coverage terminates. Conversion is not required if the group coverage was terminated for nonpayment of premium, or if coverage is replaced by similar coverage within 31 days.
- b. The premium for the individual policy must be at the insurer's customary rate for the person's age and class of risk. The effective date of the converted policy will be the day after the group coverage terminates. The converted policy must cover the employee or member and any dependents who were covered by the group policy on the date of termination. Conversion must also be made available to any covered spouse or dependent children who would otherwise lose coverage because of the death or divorce of the insured member.
- c. A notification of the conversion privilege must be included in each certificate of coverage. Each certificate holder in the insured group must be given written notice of the conversion privilege within 15 days before or after the date of termination of group coverage. If notice is given more than 15 days but less than 90 days after group coverage terminates, the conversion privilege must be extended

for 15 days after notice is actually given. If the termination notice is not given within 90 days after the date of termination of group coverage, the right to select the conversion privilege expires.

- d. A similar notice rule exists in Pennsylvania for HMO members. Notice must be given within a period beginning 15 days before and 30 days after the date of termination of the group coverage. The insured has at least 31 days following notification to exercise their conversion privilege.

9. **Entire contract [40 P.S. Sec. 753 (A)(1)]** The insurance policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed or attached. No agent has authority to change this policy or to waive any of its provisions.
10. **Time limit on certain defenses [40 P.S. Sec. 753 (A)(2)]** After three years from the date of issue of this policy, no misstatements, except fraudulent misstatements made by the applicant in the application for such policy, shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such three-year period.
11. **Grace period [40 P.S. Sec. 753 (A)(3)]** The minimum grace periods are seven days for weekly premium policies; 10 days for monthly premium policies; and 31 days for all other policies. Days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.
12. **Reinstatement [40 P.S. Sec. 753 (A)(4)]** If a premium has not been paid at renewal date, the policy may be reinstated depending on the insurance's company's guidelines with or without a reinstatement application.
13. **Claim procedures [40 P.S. Sec. 753 (A)(5-9)]**
 - a. **Notice of claim** Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible.
 - b. **Claim forms** The insurer, upon receipt of a notice of claim, will furnish to the claimant forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss.
 - c. **Proofs of loss** Written proof of loss must be furnished to the insurer at its office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon

as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

d. Time of payment of claims Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of loss.

e. Payment of claims Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment, which may be prescribed and effective at the time of payment.

- 14. Physical examinations and autopsy [40 P.S. Sec. 753 (A)(10)]** The insurer, at its own expense, shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pending of a claim and to make an autopsy in case of death where it is not forbidden by law.
- 15. Legal action [40 P.S. Sec. 753 (A)(11)]** No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.
- 16. Change of beneficiary [40 P.S. Sec. 753 (A)(12)]** Unless the policyowner makes an irrevocable designation of beneficiary, the right to change beneficiary is reserved to the owner, and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.
- 17. Optional provisions [40 P.S. Sec. 753 (B)(1-11)]** The optional provisions that are found in the license examination manual are the same as the Pennsylvania code. The following are optional provisions: change of occupation, misstatement of age, other insurance with the same or other insurer(s), unpaid premiums, cancellation, conformity with state statutes, illegal occupation, intoxicants, and narcotics.
- 18. Treatment for alcohol abuse and dependency [40 P.S. Sec. 908-1 to -8]** All group health or sickness or accident insurance policies providing hospital or medical/surgical coverage must provide coverage for alcohol dependency and abuse. Inpatient detoxification, non-hospital residential care, and outpatient care are some of the treatments available. All costs are subject to deductibles, co-payments, and coinsurance but they may not be less favorable than other forms of coverage.
- 19. Cancer benefits [40 P.S. Sec. 764b]** Whenever any individual or group health, sickness, or accident insurance policy or subscriber contract or certificate issued by any entity providing hospital or medical/surgical coverage includes within their coverage benefits for cancer chemotherapy and cancer hormone treatments and services that have been approved by the United States Food and Drug Administration for general use in treatment of cancer, the covered individual shall be entitled to benefits for cancer chemotherapy and cancer hormone treatments, whether performed in a physician's office, in an outpatient department of a hospital, in a hospital as a hospital inpatient, or in any other medically appropriate treatment setting.

20. Mammography coverage [40 P.S. Sec. 764c] All group or individual health, sickness, or accident insurance policies providing hospital or medical/surgical coverage and all group or individual subscriber contracts or certificates issued by any entity providing hospital or medical/surgical coverage shall also provide coverage for mammographic examinations. The minimum coverage required shall include all costs associated with a mammogram every year for women 40 years of age or older and with any mammogram based on a physician's recommendation for women under 40 years of age. Prior to payment for a screening mammogram, insurers shall verify that the screening mammography service provider is properly licensed.

21. Dependent child age limit [31 Pa. Code Ch. 88.32] Eligible family members may include the insured, the insured's spouse, children of the insured and of the insured's spouse who are under a specified age not to exceed 19, unless a dependency test is specified, and any other person dependent upon the insured. However, newborn children of any insured shall be covered. (Note that this rule may be overridden by the Affordable Care Act that may allow family members coverage to age 26.)

E. MARKETING REQUIREMENTS [31 PA. CODE CH. 51.1-.36, .42] In addition to the general regulations reviewed earlier that apply to life and health insurance policies, the following standards specifically apply to advertising of accident and health insurance policies in Pennsylvania.

1. Benefits payable An insurer must not represent that its claim settlements are liberal or generous, or imply that coverage or settlements will be beyond the actual terms of the contract. Advertising for benefits where payment is conditional on confinement in a hospital must not use phrases such as *tax free*, *extra cash*, *extra income*, or *extra pay* because it can mislead the public into believing they can profit from being hospitalized. Advertisements for hospital indemnity coverage must state that benefits are payable only during hospital confinement and properly identify where benefits will be computed on a daily pro rata basis.

a. Each time an advertisement mentions benefits payable, it must describe any limits on time periods or number of payments. Where a reduced initial premium rate is available, the advertisement must also state the reduced rate and the renewal rate. Where a contract provides benefits for specified illnesses only, the advertisement must clearly and conspicuously state its limits, in language such as, "THIS IS A LIMITED POLICY" or "THIS IS AN AUTOMOBILE ACCIDENT ONLY POLICY."

2. Exceptions, reductions, and limitations When an advertisement refers to specific dollar amounts, time periods, costs, losses or benefits, any reductions or limitations that affect the benefits must be clearly revealed. Waiting, elimination, probationary, or other time periods must be disclosed.

a. Advertisements may not use the words *all*, *full*, *complete*, *comprehensive*, *unlimited*, *up to*, *as high as*, *this policy will help fill some of the gaps that Medicare and your insurance leave out*, *this policy will help to replace your income*, or other similar words and phrases to exaggerate benefits beyond the terms of the policy.

- b. Policy limitations, exceptions, or reductions may not be described in a positive manner to sound like benefits, such as describing a waiting period as a “benefit builder” or stating that “even preexisting conditions are covered after two years.” The negative features of limitations, exceptions, and reductions must be described fairly and accurately.
- c. Exceptions, reductions, and limitations may not be described by using the words *only*, *just*, *merely* or *minimum*, and must not be worded positively so as to misleadingly imply some benefit. Any negative features must be fairly and accurately described.

F. EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

1. ERISA was enacted to protect the interests of participants in employee benefit plans as well as the interests of the participants’ beneficiaries. Much of the law deals with qualified pension plans, but some sections also apply to group insurance plans.
2. **Fiduciary responsibility** ERISA mandates very detailed standards for fiduciaries and other parties-in-interest of employee welfare benefit plans, including group insurance plans. This means that anyone with control over plan management or plan assets of any kind must discharge that fiduciary duty solely in the interests of the plan participants and their beneficiaries. Strict penalties are imposed on those who do not fulfill this responsibility.
3. **Reporting and disclosure** ERISA requires that certain information concerning any employee welfare benefit plan, including group insurance plans, be made available to plan participants, their beneficiaries, the Department of Labor, and the IRS. Examples of the types of information that must be distributed include:
 - a summary plan description to each plan participant and the Department of Labor;
 - a summary of material modifications that details changes in any plan description to each plan participant and the Department of Labor;
 - an annual return or report (Form 5500 or one of its variations) submitted to the IRS;
 - a summary annual report to each plan participant; and
 - any terminal report to the IRS.

G. CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

COBRA is a federal law that requires employers with 20 or more employees to provide former employees and their families a continuation of benefits under the employer’s group health insurance plan. Coverage may be continued for 18 to 36 months. Employees and other qualified family members who would otherwise lose their coverage because of a qualifying event are allowed by COBRA to continue their coverage at their own expense at specified group rates.

1. **Qualifying event** A qualifying event occurs when the employee, spouse, or dependent child becomes ineligible for coverage under the group insurance contract for the following reasons:
 - Death of a covered employee

- Termination (other than due to gross misconduct) or reduction of work hours of the covered employee
- Medicare eligibility for the covered employee
- Divorce or legal separation of the covered employee from the covered employee's spouse
- Termination of a child's dependent status
- The bankruptcy of the employer

2. **Notification statements and COBRA election** Within 14 days of the plan being notified of a qualifying event, the plan must provide the qualified beneficiaries with an election notice, which describes their rights to continuation coverage and how to make a COBRA election. An individual has 60 days after the notice in which to elect continuation. If continued coverage is not elected within 60 days, the option to do so is forfeited.

3. **Duration of coverage** An employer is not required to make continuation coverage available indefinitely. The rationale behind COBRA is to provide transitional health care coverage until the employee or family member can obtain coverage or employment elsewhere. The maximum period of coverage continuation for termination of employment or a reduction in hours of employment is 18 months. For all other qualifying events, the maximum period of coverage continuation is 36 months. If the former employee or dependents do not pay the premium on time, obtain coverage under another group plan, or become eligible for Medicare, then coverage may terminate prior to these maximum periods.

4. Premium COBRA coverage is a continuation of the exact same group coverage that the employee had as a covered employee. This distinction is important so as not to confuse this provision with the conversion of group coverage to an individual policy or individual plan.
 - a. The group premium is the same, except now the terminated employee pays the entire premium (employee and employer share) to the employer for the privilege of continuing the group benefits.
 - b. To help cover some of the administrative expense that the employer may incur, the employer may charge the former employee not more than 102% of the group premium. For example, if the total monthly group premium was \$600 per month, the employer could charge the terminated employee \$612 ($\$600 \times 102\%$).

5. Omnibus Budget Reconciliation Act of 1989 (OBRA) extended the minimum COBRA continuation of coverage period to 29 months for qualified beneficiaries disabled at the time of termination. The disability must meet the Social Security definition of disability. The plan can charge qualified beneficiaries an increased premium, up to 150% of the group premium, during the 11-month disability extension (months 19 to 29).

H. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

1. The state insurance exam content outline still shows HIPAA as an exam topic. It is important for students to know HIPAA for the exam. But, it is also important to understand that current federal law due to the Patient Protection and Affordable Care Act (PPACA) changed the preexisting conditions portion of HIPAA. PPACA was mentioned in a prior section, and is discussed in the next section.
2. HIPAA took effect July 1, 1997. It ensured portability of group insurance coverage and included various mandated benefits that affect small employers, the self-employed, pregnant women, and the mentally ill.
3. **Preexisting conditions** A group health plan may not define a preexisting condition more restrictively than: A condition in which medical advice, diagnosis, care, or treatment was recommended or received during the six months prior to the enrollment date in the plan.
 - a. A preexisting condition can be excluded for up to 12 months (18 months for a late enrollee).
4. **Creditable coverage** includes most health coverage, including coverage under a group health plan, an HMO, an individual health insurance policy, Medicaid, or Medicare. As long as there is not a break in creditable coverage of 63 or more days, an individual's prior creditable coverage reduces the maximum preexisting condition exclusion period that the new group health plan can apply to that individual. This means if an individual had prior creditable coverage of 12 months or more (18 months if a late enrollee), and there was not a gap of 63 or more days between coverage on the prior plan and the new plan then the new plan would not be allowed to apply a preexisting condition exclusion.
5. **Mandated Benefits** HIPAA guarantees coverage for a 48-hour hospital stay for new mothers and their babies after a regular delivery (96 hours for a Caesarean section birth). Also, it expands coverage for mental illness by requiring similar coverage for treatment of mental and physical conditions. The law eliminates insurance policy limits that apply only to mental health coverage. Small employers cannot be denied group health insurance coverage because one or more employees are in poor health.
6. **Privacy disclosures** HIPAA imposes specific requirements on health care providers, insurers, and producers with respect to the privacy of the insureds' health and medical information.
 - a. The applicant must be given notice of the following:
 - The insurer's privacy practices
 - The applicant's rights to maintain privacy
 - The applicant's opportunity to opt-out
 - b. The producer must provide the applicant with the Notice of Insurance Information Practices.

I. PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) On March 23, 2010, President Obama signed comprehensive health reform, the PPACA, into law. The PPACA (also referred to as the Affordable Care Act or ACA) requires most U.S. citizens and legal residents to have health insurance or pay a penalty. States are given the choice whether to create a state-based American Health Benefit Exchange (Marketplace) or offer coverage through the Federal Exchange/Marketplace. An exchange is an electronic marketplace through which individuals can purchase coverage, with premium and cost-sharing credits available to individuals/families with income between 133–400% of the federal poverty level. Small businesses can purchase coverage through the exchanges as well, possibly earning tax credits.

1. Individual mandate requires U.S. citizens and legal residents to have qualifying health care coverage. Those without coverage pay a tax penalty of the greater of \$695 per year up to a maximum of three times that amount (\$2,085) per family or 2.5% of household income. The penalty will be phased-in according to the following schedule: \$325 in 2015, and \$695 in 2016 for the flat fee or 2.0% of taxable income in 2015, and 2.5% of taxable income in 2016. Beginning after 2016, the penalty will be increased annually by the cost-of-living adjustment. Exemptions will be granted for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost plan option exceeds 9.5% of an individual's income, and those with incomes below the tax filing threshold.

2. Employer requirements Assess employers with 50 or more full-time employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit a fee of \$2,000 per full-time employee, excluding the first 30 employees from the assessment. Employers with 50 or more full-time employees that offer coverage but have at least one full-time employee receiving a premium tax credit, will pay the lesser of \$3,000 for each employee receiving a premium credit or \$2,000 for each full-time employee, excluding the first 30 employees from the assessment. Employers with less than 50 full-time employees are exempt from these penalties.

3. Benefits

a. Group health plans and health insurance issuers offering group or individual health insurance coverage that provide dependent coverage of children must generally now make coverage available for adult children up to age 26. There is no requirement to cover the child or spouse of a dependent child.

b. Qualified health plan—essential benefits Since 2014, the following “Ten Essential Benefits” must be included under all insurance plans with no lifetime or annual dollar limits to be classified as a qualified plan:

- Emergency services
- Hospitalizations
- Laboratory services
- Maternity care
- Mental health and substance abuse treatment
- Outpatient or ambulatory care
- Pediatric care

- Prescription drugs
- Preventive care
- Rehabilitative and habilitative (helping maintain daily functioning) services
- Vision and dental care screening for children

Exceptions:

- Insurance companies can still put a yearly dollar limit and a lifetime dollar limit on spending for health care services that are not considered essential health benefits.

It can be difficult to compare health insurance plans that have different benefits and out-of-pocket costs. The Affordable Care Act addresses this problem by standardizing the types of benefits and cost-sharing allowed in health plans offered by private health insurers through the Health Insurance Marketplace into four levels of coverage. Each plan level must cover the same minimum essential health benefits, but the amount of cost-sharing required will vary among the plan levels, as will the premiums charged. (As a general rule, the higher the percentage of benefit costs paid by the plan, the higher the premium for that health plan.)

- *Bronze plans* must cover 60% of the benefit costs of the plan, meaning the insured is responsible for paying the remaining 40%.
- *Silver plans* must cover 70% of the benefit costs of the plan, leaving the insured to pay the remaining 30%.
- *Gold plans* must cover 80% of the benefit costs of the plan, leaving the insured to pay the remaining 20%.
- *Platinum plans* must cover 90% of the benefit costs of the plan, leaving the insured to pay the remaining 10%.

- c. Preexisting conditions** Insurers are no longer be able to deny coverage to people with preexisting conditions or charge them more for premiums.
- d. Ban on lifetime dollar limits**
- e. Free preventive care and annual wellness visits** The PPACA focuses on prevention and primary care to help people stay healthy and to manage chronic medical conditions before they become more complex and costly to treat.
- f. Rapid appeals** Consumers can appeal insurance company decisions to an independent reviewer and receive a response in 72 hours for urgent medical situations.
- g. Preventive services** Adult services, included in the 15 preventive services for adults, are immunizations, screenings for depression, blood pressure, colorectal cancer, and high cholesterol. Diet and alcohol abuse counseling, though not considered screening services, are also included as no out-of-pocket, “first dollar” services. Children are entitled to 26 preventive services. These include a host of developmental and other screenings and immunizations:
- Abdominal aortic aneurysm one-time screening for men of specified ages who have ever smoked

- Alcohol misuse screening and counseling
- Aspirin use to prevent cardiovascular disease for men and women of certain ages
- Blood pressure screening for all adults
- Cholesterol screening for adults of certain ages or at higher risk
- Colorectal cancer screening for adults over 50
- Depression screening for adults
- Diabetes (Type 2) screening for adults with high blood pressure
- Diet counseling for adults at higher risk for chronic disease
- HIV screening for everyone ages 15 to 65 and other ages at increased risk
- Immunization vaccines for adults (doses, recommended ages, and recommended populations vary)
 - Hepatitis A
 - Hepatitis B
 - Herpes Zoster
 - Human Papillomavirus
 - Influenza (Flu Shot)
 - Measles, mumps, and rubella
 - Meningococcal
 - Pneumococcal
 - Tetanus, diphtheria, and pertussis
 - Varicella
- Obesity screening and counseling for all adults
- Sexually transmitted infection (STI) prevention counseling for adults at higher risk
- Syphilis screening for all adults at higher risk
- Tobacco use screening for all adults and cessation interventions for tobacco users

h. Women's preventative services These provisions include well-woman visits, counseling for domestic violence victims, domestic violence screenings, and contraception counseling and dispensing:

- Anemia screening on a routine basis for pregnant women
- Breast cancer genetic test counseling (BRCA) for women at higher risk for breast cancer
- Breast cancer mammography screenings every 1 to 2 years for women over 40
- Breast cancer chemoprevention counseling for women at higher risk
- Breastfeeding comprehensive support and counseling from trained providers, and access to breast feeding supplies, for pregnant and nursing women
- Cervical cancer screening for sexually active women
- Chlamydia infection screening for younger women and other women at higher risk

- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs). This does not apply to health plans sponsored by certain exempt “religious employers.”
- Domestic and interpersonal violence screening and counseling for all women
- Folic acid supplements for women who may become pregnant
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
- Gonorrhea screening for all women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visit
- HIV screening and counseling for sexually active women
- Human Papillomavirus (HPV) DNA test every three years for women with normal cytology results who are 30 or older
- Osteoporosis screening for women over age 60 depending on risk factors
- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Sexually transmitted infections counseling for sexually active women
- Syphilis screening for all pregnant women or other women at increased risk
- Tobacco use screening and interventions for all women and expanded counseling for pregnant tobacco users
- Urinary tract or other infection screening for pregnant women
- Well-woman visits to get recommended services for women under 65

i. Children's preventive services

- Autism screening for children at 18 and 24 months
- Behavioral assessments for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, and 15 to 17 years
- Blood pressure screening for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, and 15 to 17 years
- Cervical dysplasia screening for sexually active females
- Depression screening for adolescents
- Developmental screening for children under age 3
- Dyslipidemia screening for children at higher risk of lipid disorders at the following ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, and 15 to 17 years.
- Fluoride chemoprevention supplements for children without fluoride in their water source
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening for all newborns
- Height, weight, and body mass index measurements for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, and 15 to 17 years
- Hematocrit or hemoglobin screening for children

- Hemoglobinopathies or sickle cell screening for newborns
- HIV screening for adolescents at higher risk
- Hypothyroidism screening for newborns
- Immunization vaccines for children from birth to age 18 (doses, recommended ages, and recommended populations vary)
 - Diphtheria, tetanus, and pertussis
 - Haemophilus influenza type B
 - Hepatitis A
 - Hepatitis B
 - Human Papillomavirus
 - Inactivated Poliovirus
 - Influenza (flu shot)
 - Measles, mumps, and rubella
 - Meningococcal
 - Pneumococcal
 - Rotavirus
 - Varicella
- Iron supplements for children ages 6 to 12 months at risk for anemia
- Lead screening for children at risk of exposure
- Medical history for all children throughout development at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, and 15 to 17 years
- Obesity screening and counseling
- Oral health risk assessment for young children ages: 0 to 11 months, 1 to 4 years, and 5 to 10 years
- Phenylketonuria (PKU) screening for this genetic disorder in newborns
- Sexually transmitted infection (STI) prevention counseling and screening for adolescents at higher risk
- Tuberculin testing for children at higher risk of tuberculosis at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, and 15 to 17 years
- Vision screening for all children

J. DISABILITY INCOME INSURANCE Disability income protection coverage provides weekly or monthly periodic payments for a specified period during a continuing disability resulting from either sickness or injury, or a combination of both.

1. Minimum benefit standards [Pa. Code Ch. 88.167] Policies providing disability income protection coverage must:

- provide that periodic payments that are payable after age 62 and reduced solely on the basis of age are at least 50% of the amounts payable before age 62;
- contain an elimination period no greater than 90 days for coverage providing benefits for one year or less, 180 days for coverage providing benefits for more than one year but no more than two years or 365 days in all other cases; and
- have a maximum benefit period during disability of at least six months.

2. Other requirements

A disability income policy may not:

- require a loss from accidental injury to begin within less than 30 days after the accident;
- require an insured to be confined to his residence due to sickness or injury as a condition for benefits; or
- define the disability period as starting on the date when the company receives written notice.

3. Definition of disability

- a. Total disability [31 Pa Code Ch. 88.137]** For the first 24 months after the beginning of a loss, **total disability** must be defined as the inability to perform all of the substantial and material duties of the insured's own regular occupation. After 24 months of continuous disability, total disability may be defined as the inability to perform all of the substantial and material duties of any occupation for which the insured is reasonably suited by reason of education, training, or experience.

Total disability may be defined in relation to a person's inability to perform duties, but may not be based solely upon the person's ability to perform "any occupation whatsoever" or engage in any training or rehabilitation program. The definition may require that the total disability be continuous or uninterrupted for a specified period of time or to a specified age. The insured may be required to be under a doctor's care.

- b. Partial disability [31 Pa. Code Ch. 88.138]** Partial disability may be defined in relation to a person's inability to perform one or more (but not all) of the major, important, or essential duties of his employment or occupation. It may also be related to a percentage of time worked, a specified number of hours, or to compensation. When a policy provides total and partial disability benefits, only one elimination period may be required.
- c. Residual disability [31 Pa. Code Ch. 88.139]** Residual disability must be defined in relation to a person's reduction in earnings, and may be related to either being unable to perform some part of the major, important, or essential employment duties, or being unable to perform all usual business duties for as long as is usually required. A policy providing residual disability benefits may require a qualification period, where the insured must be continuously totally disabled before receiving benefits. The qualification period for residual benefits may be longer than the elimination period for total disability.

- 4. Relation of earnings to insurance [40 P.S. SEC. 753(B)(6)]** A disability income policy may provide that if the monthly benefit specified in the policy exceeds the insured's monthly pre-disability earnings, the benefit payable to the insured will be reduced proportionately. This provision may not reduce the total monthly benefits below the lesser of \$200 or the monthly benefit amount specified in the policy. The provision may be used only if the insured has the right to renew the policy until at least age 50, or for a policy issued after age 54, for at least five years.

K. LONG-TERM CARE INSURANCE [40 P.S. SECS. 991.1101 TO 1115; 31 PA. CODE CH 89A.101-129] The purpose of long-term care according to Pennsylvania insurance law is to protect purchasers of coverage from deceptive sales practices and to establish standards for this type of insurance.

1. LTC insurance is any policy or rider advertised, marketed, offered, or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense-incurred, indemnity, prepaid, or other basis for one or more necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital. Long-term care insurance will not pay for claims due to alcoholism or drug addiction, suicide or mental illness, war, or active duty in the armed services, felonies, or aviation.
2. **Marketing standards [31 Pa. Code Ch. 89a.120]** Selling excessive coverage, high-pressure tactics, and twisting (misleading or incomplete representations or fraudulent comparisons) in an attempt to sell an LTC policy are prohibited practices. Reasonable efforts must be made to determine that the purchase of an LTC policy is suitable for the individual. Companies must train their producers on proper marketing standards and procedures to ensure sales presentations and product comparisons will be fair and accurate.
3. A **Notice to Buyer** must be prominently displayed on the first page of the Outline of Coverage and the policy stating, "This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."
4. **Outline of coverage [40 P.S. Sec. 991.1111; 31 Pa. Code Ch. 89a.107, 126]** An **Outline of Coverage** must be provided by the time of application to each person applying for a LTC policy; a shoppers guide, in at least 12-point font (as opposed to at least 10 point font), must be provided to each prospect. The contents of each document are prescribed by state regulation. For example, an outline of coverage includes a description of the benefits and coverage as well as exclusions, reductions, and limitations contained in the policy.
5. **Suitability and replacement sales [31 Pa. Code CH. 89a.121, 113, 122]** Applications, which include a personal worksheet questionnaire, are to include questions designed to determine suitability and if the applicant has or had any other long-term care coverage in effect. Producers are required to list all health policies they sold to the applicant that are in force and those that were sold in the last five years that are no longer in force. If replacement is involved, a form titled *Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-Term Care Insurance* that contains a notice to the applicant regarding replacements must be signed by the applicant and the producer. If a policy is replaced, proper replacement procedures must be followed by all parties, and all preexisting condition restrictions, waiting periods, and probationary periods must be waived.
6. **Inflation protection [31 Pa. Code Ch. 89a.112]** Insurers that offer some form of inflation protection must offer each policyholder, at the time of application, the option to purchase inflation protection; benefit levels may be increased annually

or periodically at the insured's option at the rate of at least 5% per year, compounded annually. The Outline of Coverage must chart benefits with and without inflation protection.

7. The term *long-term care insurance* includes group and individual policies or riders whether issued by insurers, fraternal benefit societies, nonprofit health, hospital and medical service corporations, prepaid health plans, HMOs, or any similar organization.
8. **Unintentional lapse [31 Pa. Code Ch. 89a.106]** To prevent an unintentional lapse, no policy may be issued without the applicant providing the insurer with the name of at least one person in addition to the applicant who is to receive notification of lapse or termination, or the applicant may sign a written waiver reflecting his desire not to designate a person to receive notification. Notices of nonpayment and pending lapse must be mailed no sooner than 30 days after payment is owed and at least 30 days prior to lapse or termination. Policies must contain a reinstatement provision in the event a lapse occurs and the insurer is provided proof of cognitive impairment or functional incapacity.
9. **Required disclosure provisions [31 Pa. Code Ch. 89a.107]** include that riders and endorsements changed or added after issue must be agreed to in writing by the insured; when benefits are payable on a "reasonable and customary" or similar basis, the terms must be defined; limitations or conditions on eligibility for benefits must be described in a separate paragraph titled *Limitations or Conditions on Eligibility for Benefits*; and a brief description of the policy must appear on the first page of the policy at the top or bottom. The policy must be classified as "qualified" or "nonqualified".
10. LTC insurance may not include any policy that is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.
11. **Permitted compensation arrangements [31 Pa. Code Ch. 89a.129]** dictate that first-year commissions may not be greater than 50% of the first year premium; renewal commissions provided for a minimum of five years may not exceed 10% of the renewal premium; and if a replacement is involved, the compensation may not exceed the renewal commission paid by the replacing insurer.
12. No LTC policy may be cancelled, nonrenewed, or terminated for any reason other than nonpayment of premium.
 - a. A policy issued to an individual must be either guaranteed renewable or noncancelable. **Guaranteed renewable** means the insured has the right to continue the insurance in force by the timely payment of premiums and the insurer cannot decline to renew but may raise rates on a class basis. **Noncancelable** means the insured has the right to continue the insurance in effect by the timely payment of premiums and the insurer has no right to make any change unilaterally in the insurance or premium.

- b.** The term *level premium* may be used only when the insurer does not have the right to change the premium.
- 13. Preexisting conditions [40 P.S. Secs. 991.1105(c), 1107]** No LTC policy may include a preexisting condition exclusion provision of more than six months, nor exclude coverage for any preexisting conditions except those occurring during six months from the effective date.
- 14.** Post-claims underwriting is prohibited. An insurer must determine an applicant's acceptability as an insured before a policy is issued.
- 15. Right to examine—free look [40 P.S. Sec. 991.1110]** Individual LTC insurance policyholders and group certificate holders who contribute to the cost of coverage have the right to return the policy within 30 days of delivery and have the premium refunded if they are not satisfied for any reason. A notice regarding the free-look trial period must be prominently printed on the first page of the policy or certificate.
- 16. Benefit triggers [31 Pa. Code Ch. 89a.124, 125]** A nonqualified long-term care policy must condition payment of benefits on a determination of the insured's ability to perform "activities of daily living" and/or on cognitive impairment. Eligibility for the payment of benefits may not be more restrictive than requiring either a deficiency in the ability to perform up to three of the activities of daily living or the presence of cognitive impairment. Activities of daily living include bathing, continence, dressing, eating, toileting, and transferring.
- 17.** A qualified long-term care contract will pay only for qualified long-term care services received by a chronically ill individual provided under a plan of care prescribed and updated annually by a licensed health care practitioner. Payment of benefits is conditioned on a determination of the insured's inability to perform at least two activities of daily living for an expected period of at least 90 days due to a loss of functional capacity or to severe cognitive impairment.
- 18. Nonforfeiture benefits [31 Pa. Code Ch. 89a.123]** A policy offered with nonforfeiture benefits (mandatory after three years of coverage) must have the same coverage elements, eligibility, benefit triggers, and benefit length as coverage without nonforfeiture benefits. The offer for nonforfeiture benefits must be in writing if it is not described in the outline of coverage or other materials given to the prospective policyholder.
 - a.** If the offer made for nonforfeiture benefits is rejected, the insurer must provide the contingent benefit upon lapse. The contingent benefit will be triggered if the insurer increases the premium to a specified percentage over the insured's initial premium at policy issue, and the policy lapses within 120 days of the due date of the increased premium. Policyholders must be notified at least 30 days prior to the due date of the increased premium.

- b.** On or before the effective date of a substantial premium increase, the insurer must:
- offer to reduce policy benefits so the premium is not increased;
 - offer to convert the coverage to a paid-up status with a shortened benefit period; and
 - notify the policyholder that a default or lapse during the 120-day period after the premium increase will be considered the election of the offer to convert coverage to a paid-up status.

19. Conversion and continuation [31 Pa. Code Ch. 89a.105] Group long-term care insurance issued in Pennsylvania must provide covered individuals with a basis for continuation or conversion of coverage. This means coverage must be continued under the existing group policy when it would otherwise terminate, subject only to the continued timely payment of premium when due, or coverage must be converted (without evidence of insurability) for any insured who has been covered under the group policy for at least six months. The converted policy must be an individual LTC policy that provides benefits identical to, substantially equivalent to, or in excess of those provided under the group policy.

20. Penalties [31 Pa. Code Ch. 89a.128] In addition to other penalties provided by Pennsylvania law, an insurer or producer found to have violated requirements relating to the regulations of long-term care insurance or the marketing of long-term care insurance may be subject to civil penalties of up to three times the amount of any commissions paid for each policy involved in the violation, or \$10,000, whichever is greater.

21. Replacement [31 Pa. Code Ch. 89a.113, 122] Application forms shall include questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace another accident and sickness or long-term care policy or certificate presently in force.

22. Shopper's guide [31 Pa. Code Ch. 89a.127] A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the Commissioner, must be provided to all prospective applicants of a long-term care insurance policy or certificate.

- L. MEDICARE SUPPLEMENT POLICIES [40 P.S. SECS. 3101-3111; 31 PA. CODE CH 89.778-790]** Medicare supplement plans have been standardized by law. All insurers selling Medicare supplements must, at a minimum, make available a policy or certificate that includes only the basic core benefits (this is known as Plan A). Minimum standards [40 P. S. Sec. 3105] for Medicare supplement Plan A (core benefits) include the following:
- Coverage for Part A Medicare eligible expenses for days 61–90 not covered by Medicare
 - Coverage for Part A Medicare eligible expenses for each of the Lifetime Reserve Days not covered by Medicare
 - 100% of the Medicare eligible expenses for an additional 365 days after all of the inpatient reserve days are exhausted
 - Coverage for the reasonable cost of the first three pints of blood

- Coverage for the coinsurance amount of Medicare eligible expenses under Part B of Medicare
- Coverage of cost sharing for Part A Medicare eligible hospice care and respite care expenses

1. Permitted compensation arrangements [31 Pa. Code Ch. 89.782] First-year commissions on the sale of Medicare supplement policies may not exceed 200% of the commission paid for selling or servicing the policy in the second year. The commission or compensation provided in subsequent renewal years must be the same as provided in the second year and must be provided for at least five renewal years. Compensation for replacing an existing Medicare supplement policy may not exceed the renewal compensation normally paid by the replacing insurer.

2. Open enrollment [31 Pa. Code Ch. 89.778]

- a. An issuer may not deny or condition the issuance or effectiveness of a Medicare supplement policy or certificate, nor discriminate in the pricing of a policy or certificate, because of the applicant's health status, claims experience, receipt of health care, or medical condition if an application is submitted within six months of the first day of the first month that an individual has enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an insurer must be made available to applicants who qualify under this section without regard to age.
- b. If an applicant submits an application during the six-month period and, as of the date of application, has had a continuous period of creditable coverage of at least six months, the issuer may not exclude benefits based on a preexisting condition. If an applicant has had, as of the date of application, a continuous period of creditable coverage that is less than six months, the issuer must reduce the period of any preexisting condition exclusion by the period of creditable coverage for which the applicant was covered as of the enrollment date.

3. Guaranteed issue [31 Pa. Code Ch. 89.790]

- a. **Eligible persons** are those who had prior group health coverage or Medicare Advantage and who apply for Medicare supplement coverage within 63 days after the date of the termination or disenrollment of the prior coverage, and who submit evidence of the date of termination or disenrollment with the application.
- b. With respect to eligible persons, an issuer may not deny issuance of Medicare supplement coverage, impose any exclusion of benefits based on preexisting conditions, or discriminate in the pricing of a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition.

4. Required disclosure provisions [40 P.S. Sec. 3107; 31 Pa. Code Ch. 89.783]

- a. Each Medicare supplement policy must include a renewal or continuation provision that is appropriately captioned, on the first page of the policy, and that

describes any right of the insurer to change or increase the premium. This provision must state the duration for renewability, the term of coverage issued, and the renewal term.

- b.** Except for riders and endorsements carrying out the insured's written requests, exercising a specifically reserved policy right, or where required to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy that reduce or eliminate benefits require the insured's signed acceptance. After the date of issue, any rider or endorsement that increases benefits and requires an increase in premium must also be agreed to in writing and be signed by the insured, except when the change is required by law. If a separate additional premium is charged for any benefits provided under a rider or endorsement, the premium charge must be set forth in the policy.
- c.** A Medicare supplement policy may not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or other similar wording.
- d.** Any preexisting condition limitations must appear as a separate paragraph of the policy and be labeled "Preexisting Condition Limitations."
- e.** Medicare supplement policies or certificates must have a notice prominently printed or attached to the first page of the policy stating that the policyowner has the right to return the policy, and have the premium refunded, if the insured person is not satisfied for any reason. The insured has 30 days to return the policy. (This is known as the free-look period.)
- f.** Insurers issuing accident and sickness policies that provide hospital or medical expense coverage to a person eligible for Medicare by reason of age must provide a current Medicare supplement *Buyer's Guide*. The *Buyer's Guide* must be delivered at the time of application (or at policy delivery for direct-response insurers), and acknowledgment of receipt must be obtained. Except for direct-response insurers, a copy of the completed application must be attached to the policy.
- g.** No later than 30 days before annual Medicare benefit changes become effective, insurers must notify policyholders of any modifications made to Medicare supplement coverage due to the Medicare revisions and must notify insureds about any related premium adjustments.

5. Outline of Coverage

- a.** An Outline of Coverage must be provided to all Medicare supplement insurance applicants at the time of application, and (except for direct-response policies) an acknowledgment of receipt must be obtained. If a policy is issued on a basis that would require revision of the outline, a substitute Outline of Coverage describing the policy actually issued must accompany the policy when it is delivered and must include the following statement: *NOTICE: Read this Outline of Coverage carefully. It is not identical to the Outline of Coverage provided upon application and the coverage originally applied for has not been issued.*

- b.** The Outline of Coverage consists of four parts: a cover page, premium information, disclosure pages, and charts for each benefit plan offered by the insurer. Premium information must be shown on the cover page (or immediately following), and must be prominently identified.
- c.** The form must identify the insurance company and have a title indicating that it is an outline of Medicare supplement coverage. It should state that it is a brief description of the important features of the policy and must urge the applicant to read the policy carefully. It must describe the coverage, refer to types of benefits not provided, and summarize the gaps in Medicare and a parallel description of the benefits, including dollar amounts, provided by the policy. It must contain a statement about the right to return the policy and about policy replacement. It must also state clearly that neither the company nor its agents are connected with Medicare, and that the policy may not fully cover all medical costs.
- d.** An insurer issuing any health insurance policy other than a Medicare supplement policy to persons eligible for Medicare by reason of age must notify insureds that the policy is not a Medicare supplement policy, by including the following statement on the first page of the Outline of Coverage or the policy: *This (policy or certificate) is NOT a Medicare supplement policy. If you are eligible for Medicare, review the Medicare supplement Buyer's Guide available from the company.*

6. Replacement requirements [40 P.S. Sec. 3108; 31 Pa. Code Ch. 89.784, .789]

- a.** Application forms must inquire whether the applicant has another Medicare supplement policy, whether a Medicare supplement policy is intended to replace any other accident or sickness policy or certificate currently in force, and whether the applicant is eligible for Medicaid. The producer must also ascertain if the prospect has Medicare Advantage, in which case he or she should not purchase a Medicare supplement. This may be done using an additional form or supplementary application to be signed by the applicant.
- b.** If the sale will involve replacement, an insurer or its agent (except a direct-response insurer) must furnish the applicant with a Notice Regarding Replacement detailing the essential differences in coverage and warning the policyholder that the failure to truthfully answer all medical and health history questions on the application may cause the company to deny future claims or cancel the contract. This notice must be given prior to policy delivery (for direct-response solicitations the notice can be given at policy issuance). When an agent is involved, one copy (signed by the agent and applicant) must be left with the applicant and an additional copy must be returned to the insurer.
- c.** If a Medicare supplement policy replaces another, the replacing issuer must waive time periods for preexisting conditions, waiting periods, elimination periods, and probationary periods in the new Medicare supplement policy to the extent the time was spent under the original policy. If a Medicare supplement policy replaces another that had been in effect for at least six months, the replacing policy may not impose any time period for preexisting conditions, waiting periods, elimination periods, or probationary periods.

7. Standards for marketing [31 Pa. Code Ch. 89.786] Insurers must establish marketing procedures to assure that comparison of Medicare supplement policies by its agents or producers will be fair and accurate and to ensure that excessive insurance is not sold or issued. These procedures must establish a mechanism for determining whether a replacement policy contains benefits clearly and substantially greater than the benefits under the replaced policy.

- a. The following statement must be prominently displayed on the first page of the policy: “Notice to buyer: This policy may not cover all of your medical expenses.”
- b. In addition to the general practices that are prohibited as unfair trade practices in Pennsylvania, the following practices are also specifically prohibited in the marketing of Medicare supplement insurance:
 - **Twisting** Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.
 - **High pressure tactics** Using any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, or undue pressure to purchase or recommend the purchase of insurance.
 - **Cold lead advertising** Making direct or indirect use of any marketing method that fails to disclose in a conspicuous manner that a purpose of the marketing is to solicit insurance and that an insurance agent or insurance company will contact the prospect.
- c. The terms *Medicare Supplement*, *Medigap*, *Medicare Wrap-Around*, and similar words may not be used unless the policy is issued in compliance with these regulations.
- d. Medicare supplement advertisements intended for use in Pennsylvania (whether through written, radio, or television medium) must be filed with the Insurance Commissioner for review and approval.

8. Appropriateness of recommended purchase and excessive coverage [31 Pa. Code Ch. 89.787] In recommending the purchase or replacement of a Medicare supplement policy, an agent must make reasonable efforts to determine the appropriateness of a recommended purchase or replacement. A sale of Medicare supplement coverage that will provide an individual with more than one Medicare supplement policy or certificate is prohibited.

- a. A Medicare supplement policy may not be issued to an individual enrolled in Medicare Part C (Medicare Advantage) unless the effective date of coverage is after the termination date of the individual’s Part C coverage.

9. Advertising [31 Pa. Code Ch. 89.785] An issuer shall provide a copy of any Medicare supplement advertisement intended for use in this Commonwealth whether through written, radio, or television medium, to the Commissioner for review or approval by the Commissioner to the extent it may be required under state law.

M. SPECIFIED DISEASE OR ACCIDENT COVERAGE

1. **Specified disease coverage [31 Pa. Code, Secs. 88.169, .193]** This plan covers specifically named diseases (cancer or AIDS) and has a deductible amount of no more than \$250, an overall aggregate benefit limit of at least \$5,000, and a benefit period of at least two years. The items required to be covered include:
 - semi-private hospital room and board and other hospital furnished medical services or supplies;
 - treatment by a legally qualified physician or surgeon and private duty services of a registered nurse (RN);
 - drugs and medicines prescribed by a physician;
 - hospital confinement of at least \$100 per day for at least 500 days;
 - surgical expenses equal to reasonable and customary charges up to an overall lifetime maximum of \$3,500; and
 - radium, cobalt, chemotherapy, or X-ray therapy expenses while not hospital confined to at least \$1,000.

2. **Specified accident coverage [31 Pa. Code, Sec. 88.169]** This covers a specific kind of accident for accidental death or accidental death and dismemberment combined. The policy may include coverage for disability or hospital and medical care with a benefit amount of no less than \$1,000 for accidental death, \$1,000 for double dismemberment, and \$500 for single dismemberment. Benefit amounts may not be so limited as to be unjust, unfair, or misleading to the public.

3. **Outline of coverage** An outline of coverage must be issued with any specified disease or specified accident policy. The type of coverage must be identified in the title, and the following must be included:
 - A statement explaining that the policy is designed to provide restricted coverage paying benefits only when certain losses occur as a result of specified diseases or specified accidents and that coverage is not provided for basic hospital, basic medical-surgical, or major-medical expenses
 - A brief specific description of the policy benefits, restrictions, and exceptions
 - A description of the terms and conditions of renewability and any rights of cancellation reserved to the insured

IV. ETHICS

- A. **INTRODUCTION** Studying ethics helps producers make the right decision when they find themselves, as they often do, in ambiguous, confusing, or otherwise difficult situations. These situations may present producers with conflicts of interest or situations that may be perfectly legal but not necessarily ethical. Such situations are so common that many clients say ethical behavior is the number one characteristic they want in their insurance producer. Because strong ethical behavior is such an invaluable characteristic to an insurance producer's success, ethical insurance producers quickly gain the trust, respect, and loyalty of their clients. Such clients not only provide additional business, but also provide valuable referrals. Ethical behavior is a key ingredient of success in the insurance industry.

1. Overview of Ethics and the Insurance Producer

- a. Good ethics is good business. Ethical behavior helps insurance producers gain professional satisfaction and the respect and loyalty of clients. A code of ethics also helps a producer avoid controversy, misunderstandings, and legal entanglements, and increases personal efficiency as an insurance producer. Good clients usually refer other good clients to ethical producers.
- b. Under the law, ethical conduct is generally defined as conduct that a reasonable person is expected to do under any circumstances. However, not all actions that are unethical (such as selling a prospect more life insurance than they can afford) are illegal. A producer must pay attention to both the “have-to” legal requirements and the “choose-to” ethical standards of business.
- c. Insurance producers have ethical responsibilities to insurers, policyowners, the public, and the state. The duties of an insurance producer to the insurer are established by the concept of *agency*. This concept is tangibly represented by the agency contract, which both parties agree to and sign. As the insurer’s producer, the producer owes an insurer honesty, good faith, and loyalty. As the insurer’s representative, the producer’s day-to-day activities are a reflection of the insurer’s image within the community.

2. Compliance and market conduct

The principles of ethics are related to those of compliance and market conduct. Because these terms are in such common use, it’s important to understand the distinction between them.

- a. **Compliance** Compliance means conducting business in accordance with current rules and laws set by government regulatory agencies and the courts. It means following the rules and making sure insurance producers and companies go by the book when conducting business. Laws and regulations set the minimum standard by which producers are expected to behave. Laws and regulations tell us what we *must* do.
- b. **Ethics** Ethics are standards of conduct and moral judgment. Ethics are about what we *should* do. Codes of ethics identify and encourage desirable activities by formally establishing a high standard against which each individual may measure behavior. Characteristics of an ethical insurance producer are:
 - honesty;
 - integrity;
 - loyalty;
 - fairness;
 - compassion;
 - respect for others;
 - personal responsibility; and
 - accountability.

- c. Market conduct** Market conduct is a combination of both ethics and compliance. Market conduct refers to how insurance companies and producers conduct themselves in accordance with ethical standards and in compliance with rules and laws governing insurance policy sales, marketing, and underwriting practices as well as policy issuance, service, complaints, and terminations. Market conduct is synonymous with professional behavior.

B. THE PRODUCER'S ETHICAL RESPONSIBILITIES TO THE INSURER

- 1. Agency** The relationship between an insurance producer and the insurance company is governed by the concept of agency. Agency is a legal term that describes the relationship between two parties. One of the parties (the principal) has authorized the other (the producer) to perform certain legally binding acts on the principal's behalf. The key principles of agency law are as follows.
- The acts of the producer (within the scope of the producer's authority) are the acts of the principal.
 - A contract completed by a producer on behalf of the principal is a contract of the principal.
 - Payments made to a producer on behalf of the principal are payments to the principal.
 - Knowledge of the producer regarding business of the principal is presumed to be knowledge of the principal.
- a.** The essence of an agency relationship is power. In the case of an insurer and a producer, this power is granted through an **agency contract**, which is how an insurer appoints an individual to act on its behalf.
- b.** The agency contract gives the producer the power to act on behalf of the principal and, at the same time, describes the actions the producer is authorized to take. Practically and legally, however, a producer's authority can be quite broad.
- c.** The limits to a producer's authority are spelled out in the agency agreement, and a producer must act within those limits. The ethical significance of the agency contract is that producers must, first and foremost, serve the insurer, live up to the contract, and operate within the scope of their authority. However, a producer's duty to the insurer goes far beyond the wording of the contract. By entering into this contractual relationship, a producer also enters into a **fiduciary relationship**.
- 2. The producer as fiduciary** A **fiduciary** is an individual whose position and responsibilities involve a high degree of trust and confidence. Trustees, guardians, and executors, by virtue of their responsibilities, are fiduciaries, as are insurance producers.
- a. Authority** Through appointment, an insurance producer generally is given the power and express authority to act for the insurer by:
- soliciting applications for coverage;
 - describing coverage and policies to prospects and applicants and explaining how such policies can be purchased;

- collecting premiums (or, in some cases, only initial premiums); and
 - providing service to prospects and the insurer's policyholders.
- b. Loyalty to the insurer** The primary ethical responsibility a producer owes to the insurer is loyalty—producers must act in the insurer's best interest in every matter involving the insurer's business. Producers are also charged with conforming to the limits of their authority and staying within the guidelines of the agency contract.
- c. Care and skill** A producer has a duty to act with the utmost care and skill. In some cases, this means the producer must refer the business to others who are more qualified.
- d. Full disclosure** A producer is obligated to fully disclose all information that may affect the insurer and its ability to conduct business. Practically speaking, full disclosure is most significant during the application and claims-handling process. A producer must complete all application and claims forms as accurately and completely as possible. It is the producer's responsibility to see that the answers to questions on the application are recorded fully and accurately.
- e. Prompt action and follow-up** A producer has the obligation to act promptly in all matters regarding the insurer's business. The responsibility to transmit completed applications and notice of premium receipts as quickly as possible is most important. The insurer cannot begin the process of issuing insurance until it has received an application, and unless the applicant has been given a receipt, he remains at risk until a policy is issued. If the applicant is given a receipt at the time of application, the insurer is obligated to provide coverage until the applicant is formally rejected. In either event, a delay by the producer in turning over an application or notice of premium receipt may place the applicant or the insurer in jeopardy.
- f. Handling premiums** By law, payment of premiums to a producer is payment to the insurer. The producer has the fiduciary duty to account for all funds received in connection with the insurer's business and to turn these funds over promptly. Even if there is no illegal intent, it is unethical to delay or withhold premium payments. In many states, it is illegal to combine premium monies with personal funds, and rarely would it be ethical to do so, whether or not such a specific law exists.
- g. Avoiding conflicts of interest**
- 1.) Ethically, an insurance producer who has signed an exclusive contract with his insurer cannot serve two principals at the same time. As a captive producer, he owes a singular loyalty to that insurer. It would be unethical for that producer to represent two insurance companies selling the same policies. In addition, a producer has the ethical obligation to inform the company about any other related service he provides and receives payment for (e.g., doing part-time tax preparation and filing or consulting for a local business).

- 2.) Independent producers also face this issue when they attempt to serve their clients while being contracted to an insurer. Conflicts can be avoided if the producer represents his client only during the process of helping the client select the insurance plan best suited to the client's needs and represents the insurer at all other times.

3. Duties of the principal to the producer A rule of agency law is that the principal (insurer) is responsible for all of a producer's acts when the producer is acting within the scope of his authority. This responsibility includes fraudulent acts, omissions, and misrepresentations.

- a. The principal must select honest, loyal, and hard-working producers to protect itself from potential liability. In return, the principal gives the producer compensation for the business he brings in and reimbursement for any damages or expenses incurred in defending against claims for which the producer may be held liable in the course of fulfilling agency obligations.
- b. Perhaps the greatest source of ethical concern for many producers is the feeling that they are caught in the middle between two parties who have conflicting interests. On one hand, a producer's primary responsibility is to serve the insurer. On the other hand is the consumer, to whom the producer also owes dedication, loyalty, and service. How can a producer reconcile this conflict? Actually, it's quite simple. By acting in the best interests of the insurer, the producer best serves the consumer.

C. THE PRODUCER'S ETHICAL RESPONSIBILITIES TO THE POLICYOWNERS

- 1. Needs selling** A producer must sell the kind of policies that best fit the prospect's needs and in amounts that the prospect can afford. **Needs selling** involves problem analysis, action planning, product recommendation, and plan implementation. This requires two important commitments on the producer's part:
- A commitment to obtain and maintain the knowledge and skills necessary to perform those tasks
 - A commitment to educating the prospect or client about the products and plans that may be implemented on the producer's recommendation
- 2. Service** Service—during and after the sale—is just as important as selling to needs in meeting a producer's ethical responsibilities. One of the most important aspects of business ethics is that the characteristics associated with an ethical person—such as fairness, honesty, and personal responsiveness—also affect the level of service that a company provides. For the purposes of this discussion, service is defined to mean:
- educating the client before, during and after the sale, ensuring that he or she fully understands the application and underwriting processes, the policy purchased, and any attached riders;
 - treating all information with confidentiality;
 - disclosing all information so that the policyowner or applicant can make an informed decision;

- keeping the prospect or client informed of any rejection, exclusion, or cancellation of coverage; and
 - showing loyalty to prospects and clients.
- a. The application** A producer's primary responsibility in the application process is to the insurer. However, he also has an ethical duty to educate the prospective insured about the application process, including:
- why the information is required;
 - how it will be evaluated;
 - the need for accuracy and honesty in answering all questions; and
 - the meaning of important terms, such as *waiver of premium*, *automatic premium loan*, *nonforfeiture options*, *policy loans*, and *conditional receipt*.
- b. A conditional receipt** normally is given when the applicant pays the initial premium at the time the application for a policy is signed. This means that the applicant and the company have formed what might be called a conditional contract—that is, one contingent upon conditions that existed at the time of application or when a medical examination is completed. It provides that the applicant is covered immediately from the date of application as long as he passes the insurer's underwriting requirements. It is the producer's ethical responsibility to explain that the applicant is covered on the condition that he proves to be insurable and passes the medical exam, if required.
- c. Full disclosure** In this context, **full disclosure** means informing the prospect or client of all facts involving a specific policy or plan so that an informed decision can be made. Two forms that many producers use as educational tools and in sales presentations are *The NAIC Buyer's Guide* and *The Policy Summary*.
- d. Policy delivery**
- 1.) Most policies are issued as applied for. In such cases, the producer owes the new policyowner prompt delivery of the policy, as well as a review of its features and benefits. Not only does this help solidify the sale, it represents a step toward making the policyowner a lasting client.
 - 2.) Once the policy is issued and an applicant becomes a policyowner and client, service becomes more than the producer's ethical responsibility—service now forms the foundation on which the producer and the client form a lasting relationship. All policyowners should receive periodic reviews to ensure that their insurance programs are in step with their plans and objectives. Service after the sale is more than a responsibility; rather, it is a critical part of an insurance industry tradition. Through the years, producers have helped build that tradition, and their future success depends on continuing that tradition.

D. THE PRODUCER'S ETHICAL RESPONSIBILITIES TO THE PUBLIC An insurance producer represents his insurance company to the general public—to prospective insureds. A producer's actions help shape the public's perceptions of the insurance industry.

A producer's primary ethical duty to the public and to each prospective insured is to provide accurate information regarding insurance policies and benefits in a fair and unbiased manner. That information should be complete in every way, providing the prospect with the details of any deductibles, waiting periods, benefit limitations, exclusions, or qualification requirements for the policy.

1. **Unfair Trade Practices Act** The **Unfair Trade Practices Act** is a model act originally created by the NAIC in the 1940s to deal with the inappropriate use of advertising. It has since been expanded to include all major deceptive or unfair trade practices. Most states have adopted all or portions of the model act.
2. **Complete and honest representation** It is a producer's duty to present each policy with complete honesty and objectivity. This means pointing out any limitations or drawbacks the product may have, along with its features and benefits.

E. THE INSURANCE PRODUCER'S RESPONSIBILITIES TO THE STATE The responsibility to regulate the insurance industry is shared jointly by the federal government and the various state governments. States carry the major burden of regulating insurance affairs, including the ethical conduct of producers licensed to conduct business within their borders. This regulation of ethical conduct is called **marketing ethics**.

1. **Unauthorized insurers** By law, only insurers that have been authorized or licensed by a state may issue policies in that state. Consequently, a producer must make sure that the insurers he represents are licensed to do business where solicitation is made. Generally, a state's guaranty fund only covers the liabilities of authorized insurers, so anyone purchasing policies from unauthorized or unlicensed companies would be at risk if those insurers could not meet their claims.
2. **Misrepresentation** Any written or oral statement that does not accurately describe a policy's features, benefits, or coverage is considered a **misrepresentation**. It is unlawful to make any misleading representations or comparisons of companies or policies to insured persons to induce them to forfeit, change, or surrender that insurance. This includes unintentional misrepresentations as well.
3. **Defamation** **Defamation** is any false, maliciously critical, or derogatory communication—written or oral—that injures another's reputation, fame, or character. Individuals and companies both can be defamed. Unethical producers practice defamation by spreading rumors or falsehoods about the character of a competing producer or the financial condition of another insurance company.
4. **Rebating** Rebating occurs if the buyer of an insurance policy receives any part of the producer's commission or anything else of significant value as an inducement to purchase a policy.

Examples of rebating include:

- offering, paying, or allowing any rebate or other inducement not specified in the policy, or any special favor or advantage concerning the dividends or other benefits that will accrue, in order to place, negotiate or renew the policy;

- offering, selling, or purchasing anything of value not specified in the policy; and
- offering, paying, or allowing any rebate of any premium on any insurance policy or annuity contract.

- 5. Twisting** Twisting is the unethical act of persuading a policyowner to drop a policy solely for the purpose of selling another policy without regard to possible disadvantages to the policyowner. By definition, twisting involves some kind of misrepresentation by the producer to convince the policyowner to switch insurance companies and/or policies.
- 6. Solicitation and disclosure** Producers must provide certain disclosure documents when they solicit any insurance sale. These documents are intended to help the consumer make an informed decision about what plan of insurance is the best buy.
- 7. License suspension/termination** When it comes to the law, an unethical act can have severe repercussions. This is because what states consider unethical, they have usually made illegal. In most states a producer's license can be suspended or terminated for violating marketing ethics.



4

Practice Exam

HOW TO USE: The practice exam tests your retention of the law supplement material. After you have studied the Cram Sheets, Class Notes, and Detailed Text take the following practice exam, as well as the state specific law questions in the InsurancePro™ QBank at www.kaplanfinancial.com.

LAW SUPPLEMENT PRACTICE EXAM

Student instructions: Following your thorough study of this supplement, take this 50-question sample examination. Grade your performance using the answer key provided. Carefully review the topics pertaining to those questions answered incorrectly.

I. General Insurance

1. To be qualified for an insurance producer license in Pennsylvania, an individual applicant must have reached the age of
 - A. 18
 - B. 20
 - C. 21
 - D. 26
2. In Pennsylvania, producer appointments are made by
 - A. policyowners
 - B. insurers
 - C. the Department of Insurance
 - D. the National Association of Insurance Commissioners
3. Which of the following could be paid an insurance commission or fee?
 - A. Lenny, a retired insurance producer who no longer maintains a license but whose book of business generates policy renewals
 - B. Patricia, a employee benefits attorney who refers a business client to a producer specializing in group insurance
 - C. Both A and B
 - D. Neither A nor B
4. Executing the insurance laws of Pennsylvania is whose responsibility?
 - A. Insurance Commissioner
 - B. Insurance producers
 - C. Certified insurers
 - D. Pennsylvania legislature
5. Licensed insurance companies are subject to examination by the Department of Insurance at least
 - A. once a year
 - B. once every 3 years
 - C. once every 5 years
 - D. every time they seek to renew their licenses
6. The Insurance Commissioner is responsible for all of the following duties EXCEPT
 - A. issuing certificates of authority
 - B. enforcing provisions of the Insurance Code
 - C. conducting insurer investigations
 - D. enacting insurance laws
7. By examining an insurer's records, the Insurance Commissioner assesses the company's
 - A. profitability
 - B. compliance with state laws
 - C. workforce morale
 - D. adherence to NAIC regulations
8. The insurance industry in the United States primarily is regulated by
 - A. the SEC
 - B. the Department of the Treasury
 - C. the states
 - D. the Supreme Court
9. Prohibition against which of the following insurance practices extends to consumers as well as producers?
 - A. Twisting
 - B. Rebating
 - C. Misrepresentation
 - D. Defamation

10. An insured submits a notice of loss to his insurer, with all additional and necessary information, on January 1. As a general rule according to Pennsylvania law, by what date must the insurer complete its claims investigation?
 - A. January 31
 - B. March 31
 - C. June 30
 - D. December 31
11. Long Life Insurance Company has been rated A+ by Best's Insurance Reports. This rating indicates that Long Life has
 - A. a superior financial standing
 - B. an excellent portfolio of insurance products
 - C. an excellent record of responding to consumer complaints
 - D. never been cited by the Department of Insurance for any violation of insurance laws
12. All of the following people must be licensed to transact insurance business in Pennsylvania EXCEPT
 - A. producers who specialize in annuities
 - B. producers who work for more than one insurance company
 - C. insurance producers who hold their Chartered Life Underwriter designation
 - D. the chief financial officer of an insurer who does not solicit or negotiate risks
13. An insurance company's license to do business in Pennsylvania is called
 - A. a notice of risk assignment
 - B. a certificate of authority
 - C. a mutual benefit card
 - D. a license to solicit registration
14. In Pennsylvania, a producer's term of licensure is
 - A. 1 year
 - B. 2 years
 - C. 5 years
 - D. unlimited
15. The law requires that licensed producers advise the Insurance Department of a change in their residential or business address within how many days of such a change?
 - A. 30
 - B. 40
 - C. 45
 - D. 50
16. In Pennsylvania, all of the following are considered unfair trade practices EXCEPT
 - A. misrepresentation
 - B. rebating
 - C. replacement
 - D. defamation
17. To motivate a buyer to sign an application for insurance, a producer promises a gift of 50% of the commission. This is an example of
 - A. rebating
 - B. twisting
 - C. sharing a commission
 - D. coercion
18. The practice of using misrepresentation to induce any person to lapse, forfeit, surrender, exchange, or convert an insurance policy is also known as
 - A. twisting
 - B. rebating
 - C. unfair discrimination
 - D. coercion
19. All of the following are considered unfair claim practices EXCEPT
 - A. misrepresenting the amount of coverage payable under the policy
 - B. insisting on investigating a claim based on an uncertain cause of death
 - C. attempting to settle a claim for less than the contract provides
 - D. failing to act promptly on communications regarding claims

20. All of the following are violations of Pennsylvania insurance law EXCEPT
- A. a licensed producer accepting business that was solicited by a person who is not a licensed producer
 - B. requiring a consumer to purchase insurance from a designated financial institution as a condition of taking out a loan
 - C. a licensed producer sharing a portion of his commission with a first-time insurance buyer
 - D. a licensed producer recommending the replacement of a life insurance policy for an annuity contract
21. What is the maximum term of a temporary license that is issued as a result of a licensee's death?
- A. 30 days
 - B. 60 days
 - C. 90 days
 - D. 180 days
22. When an insurance transaction involves a replacement, a producer must do all of the following EXCEPT
- A. give the applicant a notice regarding replacement of life insurance signed by the applicant and producer
 - B. notify the existing insurer when one of its subsidiaries is the issuer of the replacement policy
 - C. make a list of all of the applicant's existing life insurance policies
 - D. obtain a signed statement from the applicant disclosing any existing insurance policies to replace
23. Any attempt by the existing insurer or its producers to dissuade a policyholder from replacing an existing insurance policy is also known as
- A. coercion
 - B. dissuasion
 - C. conservation
 - D. representation
24. The purpose of Pennsylvania's replacement regulations is to
- A. prohibit all replacement transactions by deeming them unfair methods of competition
 - B. limit replacement transactions to those that would produce premium savings for the policyholders
 - C. encourage replacement transactions as a way to promote competition
 - D. ensure that policyholders are given the information they need to make informed decisions regarding such transactions
25. Producers must report any criminal charge to the Commissioner within how many days of the charge?
- A. 5
 - B. 10
 - C. 15
 - D. 30
26. All of the following are allowable activities for an individual who holds a temporary license EXCEPT
- A. procure new business from a deceased producer's existing clients
 - B. renew the business of a deceased producer
 - C. maintain the business of a disabled producer
 - D. perform any acts necessary to keep a deceased producer's business going until the estate is settled
27. The Commissioner may deny, revoke, or suspend a producer license for any of the following EXCEPT
- A. failing to meet the annual production quota as determined by the insurer
 - B. providing false information in a license application
 - C. misappropriating money being held in a fiduciary capacity
 - D. committing a felony

28. What is the maximum period of time within which an insurance producer can reinstate a lapsed license without having to reapply for the license?
- 30 days
 - 45 days
 - 60 days
 - 1 year
29. Once appointed, a producer's appointment extends
- for 3 years
 - for 5 years
 - until the appointment is terminated by the Department of Insurance
 - until the appointment is terminated by the appointing insurer
30. Unless exempt, insurance producers must complete how many hours of approved continuing education courses during each 2-year license period?
- 12
 - 16
 - 24
 - 40
31. Which of the following life insurance prospects must be provided with a disclosure statement at the time of solicitation?
- Arnold, who is applying for a deferred fixed annuity with a \$5,000 premium deposit
 - June, who has requested the conversion of her \$100,000 term policy to a permanent plan, under policy's conversion option
 - Juan, who is applying for a second whole life policy with the same insurer, in the amount of \$250,000
 - Leana, who is applying for a \$1,000 policy on the life of her granddaughter
32. Which of the following statements regarding variable life insurance in Pennsylvania is NOT correct?
- Variable life insurance is a security.
 - The separate account that supports the policy is primarily composed of stocks and bonds.
 - Investment risk for the policy's performance is borne by the insurer.
 - All variable life policies must be filed for approval with the Commissioner.
33. In Pennsylvania, the free look period for all individual life insurance policies is how many days?
- 10
 - 21
 - 30
 - 45

II. Life Insurance

31. Life insurance policies must include a provision entitling insureds to a grace period for payment of premium, during which time the death benefit coverage continues in force. How long must this grace period last?
- 7 days or 1 week
 - 30 days or 1 month
 - 90 days or 3 months
 - 365 days or 1 year

35. All of the following are true regarding Pennsylvania's life insurance replacement regulations EXCEPT
- no replacement transaction can be completed unless and until the insured/applicant is provided with a written comparison of the policies' terms, conditions, and benefits
 - no replacement transaction can be completed unless and until the insured/applicant signs a statement verifying knowledge that a replacement will take place
 - no replacement transaction can be completed unless and until the insured/applicant is given a *Notice Regarding Replacement of Life Insurance* by the soliciting producer
 - no replacement transaction can be completed unless the insured/applicant is provided a copy of all sales proposals or other sales material
36. Under Pennsylvania's life insurance disclosure requirements, all of the following elements of an insurance policy sale must be identified and described EXCEPT
- the producer's commission
 - the policy's face amount
 - dividends payable
 - the policy's cash surrender value
37. All of the following statements regarding the treatment of life insurance policy loans in Pennsylvania are true EXCEPT
- loans do not have to be made available until a policy has been in force for 3 years
 - if a policyowner fails to repay a loan within a prescribed period of time, the policy may be voided by the insurer
 - if a policy loan is outstanding at the insured's death, the insurer may deduct the outstanding amount from the death proceeds
 - insurers may charge a variable rate of interest on their policy loans
38. Tyrone applied for a life insurance policy on April 1. The application was submitted to the insurer on April 7. The company approved the application on April 30 and issued the policy on May 5. Tyrone's producer delivered the policy to his new client on May 10. When does Tyrone's free look period begin?
- April 30
 - May 5
 - May 10
 - May 11
39. On September 1, Max turned 35. Two months later, he applied for a \$150,000 life insurance policy. His application was approved and a policy was issued, dated August 1. Which of the following statements is CORRECT?
- Max lied about his age on the application and the insurer has the right to cancel the policy.
 - The insurer violated Pennsylvania's law regarding backdating of insurance policies.
 - The policy was issued appropriately.
 - The policy will be issued with a rate-up in premium.
40. Anitra purchased a \$300,000 universal life policy from Long Life Insurance Company. Which of the following must she be given at least once a year as long as she continues to own the policy?
- A policy review by the producer who sold her the policy
 - A copy of Long Life's annual statement
 - A copy of Long Life's privacy statement
 - An offer to convert the policy to an annuity
- III. Accident and Health Insurance**
41. Health insurance policies that provide maternity benefits must provide for a minimum of how many hours of inpatient care following a Caesarean delivery?
- 24
 - 48
 - 96
 - 132

42. A health insurance policy that provides coverage for the insured's family members must provide that benefits are payable for a newly born child beginning
- A. 10 days after the insurer is notified of the birth
 - B. 30 days after the date of birth
 - C. 30 days after the child is added to the policy
 - D. at the moment of birth
43. A conversion privilege under a group health insurance plan generally must be exercised within how many days after the group coverage terminates?
- A. 31
 - B. 60
 - C. 90
 - D. 180
44. Disability income insurance policies in Pennsylvania must provide a maximum benefit period of at least
- A. 1 month
 - B. 3 months
 - C. 6 months
 - D. 1 year
45. Good Health Insurance Company's medical expense policy includes a probationary period equal to the maximum time allowed by Pennsylvania law. Which of the following statements is CORRECT?
- A. No claims are payable under the policy for the first 30 days after policy issue.
 - B. No claims are payable under the policy for the first 30 days following every policy renewal date.
 - C. The insured must have been in good health for the 30 days preceding policy application.
 - D. The insured must have been in good health for the 30 days both preceding policy application and following policy issue.
46. Chris purchased a short-term disability insurance policy from Good Health Insurance Company. The policy's face page states that coverage excludes preexisting conditions. When the policy was issued, Chris was recovering from a broken leg. A week later, Chris slipped on an icy sidewalk and broke the same leg again. How will Good Health Insurance Company likely respond to Chris's claim?
- A. It will likely deny benefits since the accident was associated with a preexisting condition.
 - B. It will likely pay the claim since it was associated with an accident, not an illness.
 - C. It will likely deny the claim, citing the probationary period exclusion.
 - D. It will likely deny the claim and cancel the policy, citing the probationary period exclusion.
47. Medicare supplement policies must provide a free look period of at least
- A. 3 days
 - B. 10 days
 - C. 20 days
 - D. 30 days
48. Specified disease coverage in Pennsylvania must provide an overall aggregate benefit limit of at least
- A. \$1,000
 - B. \$2,500
 - C. \$4,000
 - D. \$5,000

49. Long-term care insurance policies cannot define a preexisting condition more narrowly than a condition for which medical advice or treatment was recommended by or received from a provider of health care services within what time period?
- A. 3 months before the applicant goes into a nursing home
 - B. 6 months before the effective date of an insured's coverage
 - C. 1 year before the applicant submits the application
 - D. 5 years before the applicant submits the application
50. Long-term care policies must have a provision regarding reinstatement that provides for which of the following?
- A. Reinstatement of a lapsed policy if requested within 1 year of the lapse
 - B. No reinstatement of a lapsed policy for anyone over the age of 75
 - C. Reinstatement of a lapsed policy if the insurer receives proof of cognitive impairment or functional incapacity of the insured
 - D. Automatic reinstatement of a lapsed policy regardless of the reason for the lapse if the insured is over age 80

ANSWERS TO LAW SUPPLEMENT PRACTICE EXAM

- | | | | | |
|--------------|--------------|--------------|--------------|--------------|
| 1. A | 11. A | 21. D | 31. B | 41. C |
| 2. B | 12. D | 22. B | 32. C | 42. D |
| 3. C | 13. B | 23. C | 33. C | 43. A |
| 4. A | 14. B | 24. D | 34. A | 44. C |
| 5. C | 15. A | 25. D | 35. A | 45. A |
| 6. D | 16. C | 26. A | 36. A | 46. C |
| 7. B | 17. A | 27. A | 37. B | 47. D |
| 8. C | 18. A | 28. D | 38. C | 48. D |
| 9. B | 19. B | 29. D | 39. C | 49. B |
| 10. A | 20. D | 30. C | 40. C | 50. C |